

CERTIFICATE OF DEATH

Reg. Dist. No.

06196

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>9hrs 15min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Agress</u> Last <u>Agress</u>		4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-89</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumb. Window Clean-ing Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Agress</u>		14. MOTHER'S MAIDEN NAME <u>Kathleen ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Chart</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Death coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>coronary sclerosis</u> DUE TO (c) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-4</u> , 19 <u>58</u> to <u>6-15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-15</u> , 19 <u>59</u> , and that death occurred at <u>6-15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. B. Smith</u>		ADDRESS (Street, city or town, state) <u>57 Green Street, Cumb., Md.</u>	
PHYSICIAN'S NAME (Type) <u>Levin Brings M.D.</u>		DATE SIGNED <u>6-16-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	
22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUN 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MONTANA
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

DATE OF DEATH

PLACE

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF INTERVIEW

NAME OF INTERVIEWER

SIGNATURE OF DEATH REGISTRAR

NAME OF DEATH REGISTRAR

WITNESSES

NAME OF WITNESSES

NAME OF DEATH REGISTRAR

06197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS					
Allegany		1 hr		Maryland		Allegany	
Frostburg				X Frostburg			
Miners Hospital		Rt. No. 3 (Eckhart)					
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
THERESA		ALLEGRETTA		6		26th 1959.	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8- 6-1886	72 yrs.	Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own home		Conzena, Italy		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown (Giannotti)				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT (Eckhart)			
No		None		Mrs. Frank Orbello, Rt. #3, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 8 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1949 to June 26, 1959, that I last saw the deceased alive on June 26, 1959, and that death occurred at 2:00 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE		John B Davis, M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED	
FROSTBURG, MD.		2 BROADWAY		6/26/59			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		6-29-59		St. Michaels Cemetery		Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Hafer Funeral Home				DATE JUN 30 '59		Arthur S. Kraus	
Paul H. Winters, 73 E. Main, Frostburg, Md.							

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

101117

Page One of One

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Macon, Georgia	
10. DATE OF BIRTH January 19, 1933		11. PLACE OF BIRTH Macon, Georgia		12. OCCUPATION None	
13. MARITAL STATUS Single		14. EDUCATION High School		15. RELIGION None	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF NEXT OF KIN None		18. SIGNATURE OF PHYSICIAN None	
19. SIGNATURE OF CORONER None		20. SIGNATURE OF JURY None		21. SIGNATURE OF STATE ATTORNEY None	
22. SIGNATURE OF COUNTY CLERK None		23. SIGNATURE OF HEALTH COMMISSIONER None		24. SIGNATURE OF DEATH REGISTRAR None	

1

6201

CERTIFICATE OF DEATH

06198

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
c. LENGTH OF STAY IN 1b <u>56 Years</u>				d. STREET ADDRESS <u>811 Shriver Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>811 Shriver Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Kemp</u> Last <u>Arthur</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 20, 1896</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Edward D. Colgate</u>				14. MOTHER'S MAIDEN NAME <u>Clara Lenox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Robert A. Arthur</u> Address <u>Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypernephroma - Right Kidney</u> <u>180x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Metastases from Hypernephroma</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>5/19/59</u> , 19 <u>59</u> , to <u>6/13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/2</u> , 19 <u>59</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. Owensman</u> M.D.				ADDRESS (Street, city or town, state) <u>59 GREENE ST</u>			
PHYSICIAN'S NAME (Type) <u>S. G. WEISMAN MD</u>				DATE SIGNED <u>6/15/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u>				ADDRESS <u>Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 17 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carina S. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06199

6276

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale		c. LENGTH OF STAY IN 1b 6 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 546 Park Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle Baker Last Baker		4. DATE OF DEATH Month June Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1918
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Baltimore & Ohio	
11. BIRTHPLACE (State or foreign country) Petersburg, West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert W. Baker, Sr.		14. MOTHER'S MAIDEN NAME Cornelia Stevenson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Sue Baker, La Vale, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 6/20/59 , 19____, to 6/20/59 , 19____, that I last saw the deceased alive on 6/20/59 , 19____, and that death occurred at 7:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. Mathews		M.D. 49 Green St. Cumberland	
PHYSICIAN'S NAME (Type) L. B. Mathews M.D.		DATE SIGNED 6/22/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1959	
22c. NAME OF CEMETERY OR CREMATORY Restlawn Burial Park		22d. LOCATION (City, town, or county) (State) Allegany County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE JUN 29 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

10130

CERTIFICATE OF DEATH

Page One of Two

<p>1. Name of Deceased: <u>John F. Water, Christopher, Maryland</u></p>		<p>2. Date of Death: <u>June 23, 1968</u></p>	
<p>3. Place of Birth: <u>June 23, 1968</u></p>		<p>4. Age at Death: <u>23</u></p>	
<p>5. Sex: <u>Male</u></p>		<p>6. Race: <u>White</u></p>	
<p>7. Marital Status: <u>Single</u></p>		<p>8. Occupation: <u>Student</u></p>	
<p>9. Cause of Death: <u>Heart Disease</u></p>		<p>10. Manner of Death: <u>Natural</u></p>	
<p>11. Physician's Name: <u>Dr. J. F. Water</u></p>		<p>12. Hospital Name: <u>St. Mary's Hospital</u></p>	
<p>13. Date of Burial: <u>June 25, 1968</u></p>		<p>14. Place of Burial: <u>St. Mary's Cemetery</u></p>	
<p>15. Signature of Physician: <u>[Signature]</u></p>		<p>16. Signature of Registrar: <u>[Signature]</u></p>	

1

6202

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAVID Middle W Last BALDWIN				4. DATE OF DEATH Month JUNE Day 30 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 26, 1886	
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Blacksmith Railroad				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) INDIANA, Knox County	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Homer Baldwin				14. MOTHER'S MAIDEN NAME Rosese Devender			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. PATIENTS CHART			
17. INFORMANT PATIENTS CHART				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thaemia DUE TO 606X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis & Scurf infection (c) Cerebral Haemorrhage INTERVAL BETWEEN ONSET AND DEATH 3 days 3 mon 2 day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Super - Pubic Cystotomy June 28 1959							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 20 , 19 59 , to June 30 , 19 59 , that I last saw the deceased alive on June 30 , 19 59 , and that death occurred at 11:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clayton J. Smith				DATE SIGNED 7/1/59			
PHYSICIAN'S NAME (Type) C.E. DURBETT, M.D.				ADDRESS (Street, city or town, state) 236 VIRGINIA AVE., CUMBERLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-59		22c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Memorial		22d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland		24a. REC'D BY REGISTRAR JUL 6 '59	
				24b. REGISTRAR'S SIGNATURE Colburn & Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6203

CERTIFICATE OF DEATH

Reg. Dist. No.

06201

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 02 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 Park Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edith Middle Pearl Last Bowman				4. DATE OF DEATH June 22 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1895		9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Restaurant Wkr.		11. BIRTHPLACE (State or foreign country) Midland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Bowman				14. MOTHER'S MAIDEN NAME Harriett Alice Metz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-12-5054		17. INFORMANT Calvin Street Donald Brannon Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 12 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 9, 19 55 to June 22, 19 59 , that I last saw the deceased alive on June 22, 19 59 , and that death occurred at 4:10 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Overton Himmelwright M.D.				ADDRESS (Street, city or town, state) 133 Va. Avenue, Cumberland, Md.			
PHYSICIAN'S NAME (Type) G. Overton Himmelwright M.D.				DATE SIGNED 6/24/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 25, 1959		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Allegany County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				ADDRESS 133 Va. Avenue, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE JUN 29 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hauser			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

DECEASED NAME JAMES H. HARRIS		SEX Male		AGE 45	
RACE White		BIRTH DATE 1855		PLACE Baltimore, Md.	
OCCUPATION Laborer		RESIDENCE 1234 North Avenue		CITY Baltimore	
DATE OF DEATH 1900		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home	
CAUSE OF DEATH Heart Disease		DISEASE Coronary Artery Disease		SYMPTOMS Chest pain, shortness of breath	
MEDICAL HISTORY Hypertension		PRESENT ILLNESS Sudden onset of chest pain		TREATMENT None	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF WITNESSES J. H. Harris		SIGNATURE OF DECEASED J. H. Harris	
SIGNATURE OF REGISTRAR J. H. Harris		SIGNATURE OF CLERK J. H. Harris		SIGNATURE OF JURY J. H. Harris	

1

6204

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>1 Willowbrook Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>6/9/59</u> Day <u>19</u> Year <u>19</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/15/83</u>		9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pa. Johnstown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Cunningham</u>				14. MOTHER'S MAIDEN NAME <u>Nora Cunningham</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-20-6665</u>		INFORMANT <u>Pt. Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced age</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 6, 1959</u> to <u>June 9, 1959</u> , that I last saw the deceased alive on <u>June 9, 1959</u> , and that death occurred at <u>7:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J.P. Hallinan M.D.</u>				ADDRESS (Street, city or town, state) <u>Cumberland, Maryland</u>		DATE SIGNED <u>6/10/59</u>	
PHYSICIAN'S NAME (Type) <u>Dr. J.P. Hallinan</u>				<u>1140 Redford Street</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Allegany County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be written in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6277 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06203

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegheny MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegheny	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Valley Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Valley Road Cumberland, Md	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 1, Valley Road Cumberland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Burley		4. DATE OF DEATH June 23 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1951
9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Meyersdale, Pennsylvania USA	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Chancy F. Burley		14. MOTHER'S MAIDEN NAME Stella Mikrut	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, no, or unknown		16. SOCIAL SECURITY NO. Chancy Burley	
17. INFORMANT Rt. 1, Valley Road Cumberland, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage 812 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Skull Fracture DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by auto	
20c. TIME OF INJURY Month, Day, Year 11:45 June 23 1959		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street Rt. 1		20f. (City or town) RD #1 Cumberland, Alleg. Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 25, 1959	
22c. NAME OF CEMETERY OR CREMATORY Restlawn Burial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR JUN 29 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE SIGNED June 23, 1959	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capers, papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6205

CERTIFICATE OF DEATH

Reg. Dist. No.

06204

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>9Hrs. 35Min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Suzanne</u> Middle <u>Lue</u> Last <u>Butterfield</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/59</u>
9. AGE (In years last birthday) <u>752x</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXX</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Butterfield, Jr.</u>	
14. MOTHER'S MAIDEN NAME <u>Diane Dalpo</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Pt's chart.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>My drocephalus</u> <u>752x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>ly drocephalus</u> DUE TO (c) <u>ly drocephalus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>longitudinal</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>stenosis of the pulmonary artery open Botallus duct</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/7</u> , 19 <u>59</u> , to <u>6/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/7</u> , 19 <u>59</u> , and that death occurred at <u>2:45</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>55 Green St. Cumberland, Md.</u>	
ACTUAL SIGNATURE <u>Elizabeth Bridges</u>		DATE SIGNED <u>6/8/59</u>	
PHYSICIAN'S NAME (Type) <u>ELIZ. B. RINGS</u>		M.D. <u>Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 8, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Maryland</u>		ADDRESS <u>24a. REC'D BY REGISTRAR</u> <u>DATE JUN 10 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

2060273XV6

CERTIFICATE OF DEATH

6892

RECEIVED
MAY 10 1968
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE

TO BE FILLED IN BY THE REGISTRAR

1. Name of deceased	
2. Sex	
3. Age	
4. Date of death	
5. Place of death	
6. Cause of death	
7. Signature of registrar	
8. Signature of physician	
9. Signature of medical examiner	
10. Signature of coroner	
11. Signature of funeral director	
12. Signature of health officer	
13. Signature of police officer	
14. Signature of other official	
15. Signature of other official	
16. Signature of other official	
17. Signature of other official	
18. Signature of other official	
19. Signature of other official	
20. Signature of other official	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6267 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16205

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u> c. LENGTH OF STAY IN 1b <u>45 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>43 Westernport</u> d. STREET ADDRESS <u>101 Front St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Ellias</u> Middle <u>Cheshire</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1959</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 14 1886</u>		9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>				11. BIRTHPLACE (State or foreign country) <u>Augusta W. Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Mortica Cheshire</u>						14. MOTHER'S MAIDEN NAME <u>Virginia Saville</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-0-1065</u>		17. INFORMANT <u>Mrs Mildred V. Flick</u> Address _____									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerotic Cardiac Disease</u> (c), stating the underlying cause last. DUE TO _____ (c) _____												INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____											
20c. TIME OF INJURY Month, Day, Year Hour _____ o. m. _____ p. m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>W O McLane</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>June 4 1959</u>						EXAMINER'S NAME (Type) <u>W O McLane M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>W O McLane M.D.</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philom</u>				22d. LOCATION (City, town, or county) <u>Westernport</u> (State) <u>MD</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cl. Bond - Westernport, Md</u> ADDRESS _____						24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u> DATE <u>JUN 8 '59</u>				24b. REGISTRAR'S SIGNATURE _____					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6206

CERTIFICATE OF DEATH

06206

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>7 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>P.</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> , Year <u>19 59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 9, 1881</u>
9. AGE (In years last birthday) yrs. <u>78</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Locomotive Engineer Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>McCooe, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Clark</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Fournier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-14-II32</u>	
17. INFORMANT <u>Edgar Cole</u>		Address <u>208 Seymour St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis</u> DUE TO <u> </u> (c) <u>Carcinoma of Prostate</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>3 mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1, 1959</u> to <u>June 15, 1959</u> that I last saw the deceased alive on <u>June 15, 1959</u> and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clay E. Durrett</u> M.D.		ADDRESS (Street, city or town, state) <u>236 Va. Ave. Cumberland, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Clay E. Durrett</u>		DATE SIGNED <u>6/17/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6207

CERTIFICATE OF DEATH

06207

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LETHA Middle M. Last CONNELL		4. DATE OF DEATH Month JUNE Day 8 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 4 1894
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Berkley Spring, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE H. AMBROSE		14. MOTHER'S MAIDEN NAME REBECCA SHIRLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. ADDRESS MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple pulmonary infarction DUE TO (c) Generalized arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 55 , to June 8 , 19 59 , that I last saw the deceased alive on June 8 , 19 59 , and that death occurred at 1:15 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 128 Union St 6/9/59 ACTUAL SIGNATURE George M. Simons M.D. PHYSICIAN'S NAME (Type) DR. G. M. SIMONS Cumberland Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-II-59	
22c. NAME OF CEMETERY OR CREMATORY St. Marys Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Cumberland, Md. James F. Scarpelli		24a. REC'D BY REGISTRAR JUN 12 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Krand			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED

DECEASED

DATE

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DECEASED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.	
c. LENGTH OF STAY IN 1b Lifetime		d. STREET ADDRESS 429 Henderson Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 429 Henderson Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hazel Middle Crowford Last CRAWFORD		4. DATE OF DEATH Month June Day 10 Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Keller		14. MOTHER'S MAIDEN NAME Anna Copeland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles G. Crowford		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO 2 years (c)		INTERVAL BETWEEN ONSET AND DEATH 4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 19 59 to June 10, 19 59 that I last saw the deceased alive on June 10, 19 59 and that death occurred at 6:45 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James T. Johnson Jr. M.D. 16 Green St. Cumberland Md 6/11/59		DATE SIGNED	
PHYSICIAN'S NAME (Type) James T. Johnson Jr.		16 Green St. Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-59	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JUN 15 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

96382

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1920</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1945</i>	
9. NAME OF SPOUSE <i>Jane Doe</i>		10. PLACE OF MARRIAGE <i>Baltimore, Md.</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>		12. PLACE OF DEATH <i>Home</i>	
13. DATE OF DEATH <i>Dec 10 1965</i>		14. TIME OF DEATH <i>10:30 AM</i>	
15. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>		16. SIGNATURE OF REGISTRAR <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>	
39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
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45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
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49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

FROM

6209

CERTIFICATE OF DEATH

06209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLIS Middle E. Last CROWE				4. DATE OF DEATH Month JUNE Day 10 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/13/12	
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spinner				10b. KIND OF BUSINESS OR INDUSTRY CELANESE			
13. FATHER'S NAME GEORGE CROWE				14. MOTHER'S MAIDEN NAME ANNA L. Steinla			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 214-07-6883			
17. INFORMANT PATIENTS CHART				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190.9 Melanoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) / DUE TO (c) /							INTERVAL BETWEEN ONSET AND DEATH 4 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3-2- , 19 59 , to 6-10 , 19 59 , that I last saw the deceased alive on 6-10 , 19 59 , and that death occurred at 1:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE L. Brings M.D.							
PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.				57 GREENE ST., CUMBERLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/59		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Pk.		22d. LOCATION (City, town, or county) (State) Cumberland MD	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. ADDRESS Cumb. MD.				24a. REC'D BY REGISTRAR JUN 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR A MARRIED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6210

CERTIFICATE OF DEATH

06210

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>1 215 Decatur Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>H.</u> Last <u>Danner</u>				4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/02</u>		9. AGE (In years lost birthday) yrs. <u>57</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Danner</u>				14. MOTHER'S MAIDEN NAME <u>Louise Bachman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Pt's chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic Poisoning</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute pyelonephritis, bilateral</u> DUE TO (c) <u>Severe Anemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 da.</u> <u>10 da.</u> <u>10 da.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Extensive degenerative arthritis of the spine</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 15</u> , 19 <u>59</u> , to <u>June 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>59</u> , and that death occurred at <u>9:55 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>140 Bedford Street, Cumb., Md.</u> DATE SIGNED <u>6/22/59</u>							
ACTUAL SIGNATURE <u>J.P. Hallinan</u>		M.D. <u>140 Bedford Street</u>					
PHYSICIAN'S NAME (Type) <u>J.P. Hallinan, M.D.</u>		<u>140 Bedford Street, Cumb., Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wilderess Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

10510

CERTIFICATE OF DEATH

10510

RECEIVED
MAY 10 1964
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
BUREAU OF VITAL STATISTICS

1. Name of deceased: John Doe

2. Sex: Male

3. Race: White

4. Date of birth: 1/1/1920

5. Place of birth: New York, N.Y.

6. Date of death: 10/1/1964

7. Place of death: New York, N.Y.

8. Cause of death: Heart Disease

9. Duration of illness: 1 year

10. Signature of physician: Dr. J. Doe

11. Signature of registrar: J. Doe

12. Date of registration: 10/1/1964

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6278 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Box 85, Oldtown		c. LENGTH OF STAY IN lb 71 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Box 85, Oldtown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 1, Oldtown				d. STREET ADDRESS Rt. 1, Oldtown, Maryland		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Florence Davis				4. DATE OF DEATH Month June Day 28 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1887		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) T. 1, Oldtown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jesse Robinette				14. MOTHER'S MAIDEN NAME Ruhamey Hamilton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Rt. 1, Box 85 Frank Davis Oldtown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden ****	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease, Cardiac hypertrophy							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 29, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Meth. Cem.		22d. LOCATION (City, town, or county) (State) Allegany County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE JUL 1 '59		24b. REGISTRAR'S SIGNATURE William S. Kraus	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

80211

1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Birth: [illegible]
5. Date of Death: [illegible]
6. Place of Death: [illegible]
7. Cause of Death: [illegible]
8. Manner of Death: [illegible]
9. Signature of Examiner: [illegible]
10. Date of Examination: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6211

CERTIFICATE OF DEATH

Reg. Dist. No.

07400

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY Hampshire			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS Greenspring 85 x -3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Lee Porty Dean				4. DATE OF DEATH Month Day Year June 23, 1959 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 12, 1902	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hampshire, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Issac S. Dean				14. MOTHER'S MAIDEN NAME Minnie B. Buckley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705-10-5925		17. INFORMANT Mrs. Lee P. Dean Address Greenspring, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 10 minutes							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State) Greenspring W. Va.			
21. I certify that I attended the deceased from June 10, 1959 to June 23, 1959 that I lost saw the deceased olive on June 19, 1959 and that death occurred at 3:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED B. M. Schindler M.D. 43 Greene St. Cumberland Md 7/2/59							
ACTUAL SIGNATURE B. M. Schindler M.D. 43 Greene St. Cumberland Md 7/2/59							
PHYSICIAN'S NAME (Type) B. M. Schindler, M.D., 43 Greene Street, Cumberland, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 26, 1959		22c. NAME OF CEMETERY OR CREMATORY Forest Glenn		22d. LOCATION (City, town, or county) (State) Greenspring W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Keith Steffen ADDRESS Romney W. Va.				24a. REC'D BY REGISTRAR DATE JUL 24 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

6212

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>1 Mo- 12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. STREET ADDRESS <u>202 Prince George St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Cecilia</u> Last <u>Dempsey</u>				4. DATE OF DEATH Month <u>6/26/59</u> Day <u>19</u> Year <u>19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/7/85</u>	
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min.		11. IF UNDER 24 HRS. Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Swanhome</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland Barton</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Dempsey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Broderick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Pt's Chart</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration + Uremia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cordis - Vascular Disease</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia, severe</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/12</u> , 19 <u>59</u> , to <u>6/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/25</u> , 19 <u>59</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo H. Ley Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>456 N. Centre St. Cumberland Md</u>			
PHYSICIAN'S NAME (Type) <u>LEO H. LEY JR.</u>				DATE SIGNED <u>6/26/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Gabriels Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Barton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli</u>				ADDRESS <u>Cumberland, Md.</u>			
24a. REC'D BY REGISTRAR <u>JUN 30 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1912
CERTIFICATE OF DEATH

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6213 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> COUNTY <u>Bedford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN lb <u>10 Min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Hyndman</u> <u>75X-3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Elwood</u> Last <u>Deneen Jr.</u>			4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1920</u>		9. AGE (In years last birthday) <u>38</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hyndman, Pa.</u>	
13. FATHER'S NAME <u>Walter Deneen</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
14. MOTHER'S MAIDEN NAME <u>Esther Baer Deneen</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>Yes</u> <u>WW2</u>		
16. SOCIAL SECURITY NO. <u>173-14-3758</u>			17. INFORMANT <u>Mrs. Betty Deneen, Hyndman, Pa.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self Inflicted gunshot wound of head</u>			
20c. TIME OF INJURY Month, Day, Year <u>9:15</u> <u>Hour</u> <u>p. m.</u> <u>June 12</u> <u>1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Hyndman, Bedford, Penna</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 12, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 16, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hyndman, Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyndman, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Seegler</u>		ADDRESS <u>Hyndman, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE
OF PENNSYLVANIA



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06214

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany 6214 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital (2 hours)				/d. STREET ADDRESS 15-A Jane Frazer Village		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle U. Last Dever				4. DATE OF DEATH Month June Day 14 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1897		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dubbler Retired		10b. KIND OF BUSINESS OR INDUSTRY Tin Mill		11. BIRTHPLACE (State or foreign country) Rawlings, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Dever				14. MOTHER'S MAIDEN NAME Missouri Ullum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-05-9365		17. INFORMANT Mrs. George Dever, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac dilatation; toxemia 490x DUE TO Conditions, if any, which gave rise to immediate cause (b) Lobar pneumonia (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3-4 hrs. 2-1 Wks (?)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 14, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 17, 1959		22c. NAME OF CEMETERY OR CREMATORY Dever Cemetery		22d. LOCATION (City, town, or county) (State) Near Wiley Ford, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR JUN 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

HEALTH DEPT.
FOR STATE

1

HEALTH DEPT.
FOR STATE

HEALTH DEPT.
FOR STATE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe	
2. AGE 45	
3. SEX Male	
4. RACE White	
5. BIRTH DATE 1910	
6. PLACE OF BIRTH Baltimore, Md.	
7. OCCUPATION Teacher	
8. MARITAL STATUS Married	
9. EDUCATION High School	
10. RELIGION Roman Catholic	
11. PRESENT ADDRESS 123 Main St., Baltimore, Md.	
12. DATE OF DEATH 1955	
13. TIME OF DEATH 10:00 AM	
14. PLACE OF DEATH Home	
15. CAUSE OF DEATH Myocardial Infarction	
16. MANNER OF DEATH Natural	
17. SIGNATURE OF EXAMINER [Signature]	
18. DATE OF EXAMINATION 1955	
19. SIGNATURE OF WITNESS [Signature]	
20. DATE OF WITNESSING 1955	

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

6216

CERTIFICATE OF DEATH

06216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 25 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS RT.#1, BOX 146		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle Last DUNN				4. DATE OF DEATH Month JUNE Day 21 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 13		9. AGE (In years last birthday) 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE MILLER				14. MOTHER'S MAIDEN NAME VICTORIA BUSKIRK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive and arteriosclerotic Cardio-vascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 25 days 5 years							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 p.m. , 19 58 , to 21 June , 19 59 , that I last saw the deceased alive on 21 June , 19 59 , and that death occurred at 11:30 AM on the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Ormer		M.D. 122 S. Centre St		DATE SIGNED 22 June 59		ADDRESS (Street, city or town, state) Cumberland, Md.	
PHYSICIAN'S NAME (Type) W. A. VAN ORMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-24-59		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE JUN 25 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

40316

CERTIFICATE OF DEATH

40316

ALLIANCE

MARYLAND

MARYLAND

PROTESTANT

23 DAYS

DECEASED

ST. EL. BOX 146

MEMORIAL HOSPITAL
MEMORIAL AVENUE

MINUTE

JUNE 12

WHITE

MARYLAND

own home

Flowerbury

VICTORIA BUSHN

GEORGE MILLER

CENTRAL HOSPITAL, GUNTERLAND, MARYLAND



J. A. VAN CREEK

6-2-22

Providence, R.I.

George W. Smith

6217

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 51 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Martin Melville Garletts				4. DATE OF DEATH Month June Day 28 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7 1904		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Rockwood, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Phillip Garletts				14. MOTHER'S MAIDEN NAME Ada Coddington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 217-03-6506		17. INFORMANT Address Mrs. Doris Garletts Rt. # 6 Cumberland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis DUE TO (c) Arteriosclerosis + Hypertension						INTERVAL BETWEEN ONSET AND DEATH 3 weeks 1 year 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic Heart Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 , to June 28 , 19 59 , that I last saw the deceased alive on June 27, 1959 , and that death occurred at 7:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE D. Green				ADDRESS (Street, city or town, state) 59 GREENE ST		DATE SIGNED 6/29/59	
PHYSICIAN'S NAME (Type) SG WEISMAN				CUMBERLAND MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/1/59		22c. NAME OF CEMETERY OR CREMATORY Addison Cemetery		22d. LOCATION (City, town, or county) (State) Addison, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE JUL 2 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06218

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany 6279 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		c. LENGTH OF STAY IN 1b 73 Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dogwood St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hugh Gattens		4. DATE OF DEATH June 14 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Miner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Gattens		14. MOTHER'S MAIDEN NAME Amandana Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Floyd Gattens—Barton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation 422.2 DUE TO Conditions, if any, which gave rise to the immediate cause (b) Chr Myocardial Insufficiency (c) 3 years DUE TO cause lost.		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. O. McLane		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. O. McLane		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/16/59	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) (State) Moscow Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Roy		24a. REC'D BY REGISTRAR DATE JUN 16 '59	
ADDRESS Westernport, Md.		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, HAS RECEIVED THE FOLLOWING REPORT FROM THE MEDICAL EXAMINER:

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6218

CERTIFICATE OF DEATH

06219

Reg. Dist. No.

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VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 12 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIE Middle W. Last GEORG		4. DATE OF DEATH Month JUNE Day 29 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 4
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 47 Days 47 Hours 47 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY ACCIDENT, MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN GOEHINGER		14. MOTHER'S MAIDEN NAME MATILDA ZINKEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL	
17. INFORMANT CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Transverse Colon. 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal Perforation DUE TO (c) Peritonitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma Rectum sigmoid. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 29 June 59 ACTUAL SIGNATURE Fuller B. Whitworth M.D. PHYSICIAN'S NAME (Type) DR. FULLER WHITWORTH			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/2/59	
22c. NAME OF CEMETERY OR CREMATORY ZION LUTHERAN		22d. LOCATION (City, town, or county) (State) ACCIDENT GARRETT Co, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman		24a. REC'D BY REGISTRAR DATE JUL 7 '59	
ADDRESS Grantsville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

6218 CERTIFICATE OF DEATH

CERTIFICATE

MARYLAND

ALLEGANY

DECEASED

12 DAYS

CITY OF

RECEIVED & RECORDED

AGE

SEX

RACE

STATUS - WHITE

WT

HEIGHT

U.S.A.

ACCIDENT

MATERNAL

LOCAL

CITY OF

RECEIVED & RECORDED

1

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RECEIVED & RECORDED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06220

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany 6280 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Porter Road		e. STREET ADDRESS Porter Road	
3. NAME OF DECEASED (Type or print) First Janet Middle Earline Last Green		4. DATE OF DEATH Month June Day 10 Year 1959	
5. SEX Female	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-1959
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		Miner's Hospital	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles D. Green		14. MOTHER'S MAIDEN NAME Fanny Belle Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Charles D. Green, Father, Eckhart, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.0 DUE TO Acute Gastro Enteritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malnutrition (c)		INTERVAL BETWEEN ONSET AND DEATH 3 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. O. McLane M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. O. McLane		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-1959	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Pk. Frostburg Md.		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Hattley		24a. REC'D BY REGISTRAR DATE JUN 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

522

6219

CERTIFICATE OF DEATH

Reg. Dist. No. 06221

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 02 CUMBERLAND, BOWLING GREEN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. MEMORIAL HOSPITAL				d. STREET ADDRESS 1 CRESAP DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SYDNEY Middle GREEN Last GREEN				4. DATE OF DEATH Month JUNE Day 15 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-1882	
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED-U. S. GOV'T		10b. KIND OF BUSINESS OR INDUSTRY AIR SERVICE	
11. BIRTHPLACE (State or foreign country) VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME SYDNEY GREEN				14. MOTHER'S MAIDEN NAME MARY PLUMMER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 210-14-7064			
17. INFORMANT MRS. LOUISE GUNTER, CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH Immediate 16 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hiatus Hernia ulcer Syndrome				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 19 50 , to June 15 , 19 59 , that I last saw the deceased alive on May , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 GREENE ST., DATE SIGNED 6/16/59							
ACTUAL SIGNATURE S. G. Weisman M.D. 59 GREENE ST.,				DATE SIGNED 6/16/59			
PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN CUMBERLAND, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 6-17-59		22c. NAME OF CEMETERY OR CREMATORY Homewood Cemetery		22d. LOCATION (City, town, or county) (State) Pittsburgh, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. DURST, ADDRESS FROSTBURG, MD.				24a. REC'D BY REGISTRAR JUN 18 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First HOMER		Middle C.		Last GRIFFITH		4. DATE OF DEATH		Month JUNE	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 2		9. AGE (In years last birthday) yrs. 45		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROPRIETOR		10b. KIND OF BUSINESS OR INDUSTRY POTOMAC FRUIT CO.		11. BIRTHPLACE (State or foreign country) ECKHART, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME HERBERT GRIFFITH						14. MOTHER'S MAIDEN NAME SOPHIA PORTER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-01-8795		INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Acute congestive heart failure DUE TO (b) Metastatic carcinoma of left lung DUE TO (c) Carcinoma of left lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 2 hours 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from June 4, 1959 , to June 5, 1959 , that I last saw the deceased alive on June 5, 1959 , and that death occurred at 10:20 AM , from the causes and on the date stated above.											
ACTUAL SIGNATURE Thomas F. Lewis		THOMAS F. LEWIS		M.D.		ADDRESS (Street, city or town, state) Hotel Algonquin		DATE SIGNED 6/6/59			
PHYSICIAN'S NAME (Type) DR. XXXXXXXXXXXXXXXX		Cumberland, Md									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 8 '59		22c. NAME OF CEMETERY OR CREMATORY F'BG. MEMORIAL PARK		22d. LOCATION (City, town, or county) FROSTBURG,		(State) MD.			
23. FUNERAL DIRECTOR'S SIGNATURE J. R. DURST, FROSTBURG, MD.				ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp			

1933

DEPARTMENT OF HEALTH

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POTOMAC STEEL CO. COMPANY, BALTIMORE

PROSTATE

SPERM. POTOMAC

SPERM. POTOMAC

COVERLAND, INDIAN

GENERAL HOSPITAL

PROSTATE

THOMAS E. BROWN
DR. DENTISTRY

NO.

WESTMINSTER

JUNE 8 1933

PROSTATE

J. R. GUEST, PROSTATE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6221

CERTIFICATE OF DEATH

06223

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give address) MEMORIAL HOSPITAL AVE.,				d. STREET ADDRESS 232 BEALL STREET			
3. NAME OF DECEASED (Type or print) First KATHRYN Middle LeClair Last GRIFFITH				4. DATE OF DEATH Month JUNE Day 16 Year 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 8 1876	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JETHRO GRIFFITH				14. MOTHER'S MAIDEN NAME HILL, LIDA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT		Address MEMORIAL HOSPITAL CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 yr.						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/5/58 , 19___, to 6/14/59 , 19___, that I last saw the deceased alive on 6/14/59 , 19___, and that death occurred at 8:50 P M , from the causes and on the date stated above. ACTUAL SIGNATURE DR. RICHARD WILLIAMS ADDRESS (Street, city or town, state) DATE SIGNED 6/14/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 19, 1959		22c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE JUN 22 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

1881

CERTIFICATE OF DEATH

1881

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[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "DEATH", "CERTIFICATE", and "1881" are visible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6281

CERTIFICATE OF DEATH

06224

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Westernport		c. LENGTH OF STAY IN 1b 82 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Westernport			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 Mi. E. Westernport				d. STREET ADDRESS 3 Mi E. Westernport		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Franklin Last Grove				4. DATE OF DEATH Month June Day 7 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 18, 1876	
9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Grove				14. MOTHER'S MAIDEN NAME Harriett Ann Sigler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		INFORMANT Address Mrs. Lloyd Mrs. Jacob Blizzard-Westernport, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 years (c) 5 years							INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 10, 1954 , to June 7, 1959 , that I last saw the deceased alive on June 7, 1959 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul R. W. Isom		M.D. 111 Ashfield St. Parkland 114 DATE SIGNED 6-8-59					
PHYSICIAN'S NAME (Type) Paul R. W. Isom M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/59		22c. NAME OF CEMETERY OR CREMATORY Duckworth		22d. LOCATION (City, town, or county) (State) R.D. Westernport-Alle-Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Boral				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE JUN 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1980

CERTIFICATE OF DEATH

1980



Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint, illegible text visible in the background.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6282

CERTIFICATE OF DEATH

06225

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b 3 yrs.		d. STREET ADDRESS Route 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Etta Middle Mae Last Hanifin		4. DATE OF DEATH Month June Day 6 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1899
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 6 Days 6 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Retail Mdse.	
11. BIRTHPLACE (State or foreign country) Elkins, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Hanifin		14. MOTHER'S MAIDEN NAME Carrie Hartman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 578-12-4491	
17. INFORMANT John V. Hanifin, Rt. 3, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast (Left) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 15, 1955 to June 6, 1959 , that I last saw the deceased alive on May 25, 1959 , and that death occurred at 1:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 S. Centre Street DATE SIGNED June 8, 1959			
ACTUAL SIGNATURE Richard J. Williams M.D.		DATE SIGNED June 8, 1959	
PHYSICIAN'S NAME (Type) Richard J. Williams M.D.		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-10-1959	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUN 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Thomas			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> 6222 <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>39 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Henckel</u> Last <u>Henckel</u>		4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-79</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Valentine Henckel</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Snyder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>pt's chart</u>		16. SOCIAL SECURITY NO. <u>pt's chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u> 151X DUE TO <u>metastasis to liver & pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Cachexia</u> (b) <u>2 months</u> (c) <u>2 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Approx 2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 12, 1959</u> to <u>June 16, 1959</u> that I last saw the deceased alive on <u>June 16, 1959</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. M. Faw, Jr.</u>		DATE SIGNED <u>June 17 '59</u>	
PHYSICIAN'S NAME (Type) <u>W. M. FAW, JR., M. D.</u>		<u>122 S. CENTRE ST.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-19-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. PATRICK'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MT. SAVAGE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. DURST, FROSTBURG, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 19 1959</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

062

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VS A15 (4)
15M 9/58

Journal of Management Inquiry 20(4) 401-416

6223

CERTIFICATE OF DEATH

06227

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 112 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVENUES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle A Last HIGGINS		4. DATE OF DEATH Month JUNE Day 1 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 13, 1885
9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Janitor		10b. KIND OF BUSINESS OR INDUSTRY Public High School	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHESTER K. HIGGINS		14. MOTHER'S MAIDEN NAME CHARLOTTE HUNT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-4516	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) Arteriosclerotic Cardiovascular Disease (c) Pulmonary Infection..			INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Thrombophlebitis of left lower extremity & gangrene of left foot			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan , 19 59 , to June , 19 59 , that I last saw the deceased alive on June 1 , 19 59 , and that death occurred at 4:28 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Overton Himmelmright M.D.		ADDRESS (Street, city or town, state) 133 W. Ave, Cumberland, Md. DATE SIGNED 6/2/59	
PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 4, 1959	22c. NAME OF CEMETERY OR CREMATORY Restlawn Gardens	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JUN 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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10323

CERTIFICATE OF DEATH

1933

NAME OF DECEASED: ALBERT J. HARRIS

DATE OF DEATH: JANUARY 15, 1933

PLACE OF DEATH: HOSPITAL, CHARLOTTE, N.C.

AGE: 45 YEARS

SEX: MALE

RACE: WHITE

DATE OF BIRTH: JULY 10, 1887

PLACE OF BIRTH: CHARLOTTE, N.C.

EDUCATION: HIGH SCHOOL

OCCUPATION: LABORER

CAUSE OF DEATH: HEART DISEASE

DECEASED'S SIGNATURE: [Signature]

DECEASED'S ADDRESS: 1234 MAIN ST., CHARLOTTE, N.C.

DECEASED'S RELIGION: METHODIST

DECEASED'S MARRIAGE: MARRIED

DECEASED'S PRESENT ADDRESS: 1234 MAIN ST., CHARLOTTE, N.C.

DECEASED'S PRESENT OCCUPATION: LABORER

DECEASED'S PRESENT RESIDENCE: 1234 MAIN ST., CHARLOTTE, N.C.

6224

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 4/26/59	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage	
3. NAME OF DECEASED (Type or print) Sarah Elizabeth Hilton		4. DATE OF DEATH June 26, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/2/1887
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Mt. Savage, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Henry Derrick	
14. MOTHER'S MAIDEN NAME Alice Reed		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT P.O. Box 599 Allegany County Infirmary Records Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Hemorrhage DUE TO (c) Cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 12 hrs ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic hepatitis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/26/59 , 19____, to 6/26/59 , 19____, that I last saw the deceased alive on 6/25/59 , 19____, and that death occurred at 8:40A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 6/26/59	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/29/59	22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery	22d. LOCATION (City, town, or county) (State) Eckhart, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Haper, Cumberland, Md. ADDRESS		24a. REC'D BY REGISTRAR JUL 1 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Finner

1

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1930

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color	
James Henry Hobson		38		Male		White		White	
Date of Death		Place of Death		Cause of Death		Disease		Occupation	
Jan 10, 1930		St. James Hospital, Baltimore, Md.		Pneumonia		Pneumonia		Clerk	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Undertaker	
J. H. Hobson		J. H. Hobson		J. H. Hobson		J. H. Hobson		J. H. Hobson	
Residence		Place of Birth		Date of Birth		Date of Marriage		Date of Death	
St. James Hospital, Baltimore, Md.		St. James Hospital, Baltimore, Md.		Jan 10, 1930		Jan 10, 1930		Jan 10, 1930	
County		State		City		Town		Village	
Baltimore		Maryland		Baltimore		Baltimore		Baltimore	
Name of Undertaker		Name of Coroner		Name of Minister		Name of Registrar		Name of Physician	
J. H. Hobson		J. H. Hobson		J. H. Hobson		J. H. Hobson		J. H. Hobson	
Signature of Undertaker		Signature of Coroner		Signature of Minister		Signature of Registrar		Signature of Physician	
J. H. Hobson		J. H. Hobson		J. H. Hobson		J. H. Hobson		J. H. Hobson	

MISS

CERTIFICATE OF DEATH

1922

WEDNESDAY

WEDNESDAY

DECEASED

3 DAYS

DECEASED

1100 10000 0000

1100 10000 0000

DATE OF DEATH

WEDNESDAY

AT

THIRTY

1100 10000 0000

WHITE

MALE

1100

1100 10000 0000

WILLIAM A. HUNTER

MARY E. HUNTER

1100 10000 0000

HUNTER HOSPITAL

HUNTER

1100 10000 0000

1100 10000 0000

1100 10000 0000

1100 10000 0000

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1100 10000 0000

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Items 11, 12 Film G244 6-30-59 et									
6226 CERTIFICATE OF DEATH 06230									
Reg. Dist. No.									
1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BARTON				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.					d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MRS. ESTELLA HOFFA					4. DATE OF DEATH Month Day Year JUNE 19 19 59				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/19		9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME DANIEL STEWART					14. MOTHER'S MAIDEN NAME HATTIE ROSS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Hyper-tensive Cardio-vascular disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7-5-59 to 6-19-59 that I last saw the deceased alive on 6-18-59 , and that death occurred at 7:50AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 6-19-59 ACTUAL SIGNATURE Wm. F. Williams M.D. PHYSICIAN'S NAME (Type) DR. W.F.WILLIAMS 1228 S. CENTRE ST. CUMBERLAND, MD.									
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF 6/22/59		22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport Md		
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Beal					ADDRESS Westernport, Md		24a. REC'D BY REGISTRAR JUN 24 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kenna

207-2170

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NOTE

6227

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>ALLEGANY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>GA MD</u> b. COUNTY <u>GARRETT</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CUMBERLAND MD</u> | | | | c. LENGTH OF STAY IN 1b
<u>2 WEEKS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>MEMORIAL HOSP</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>FRANK</u> Middle <u>HUTZEL</u> Last <u>HUTZEL</u> | | | | 4. DATE OF DEATH
Month <u>JUNE</u> Day <u>30</u> Year <u>1959</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>DEC. 10, 1893</u> | 9. AGE (In years last birthday)
<u>65</u> yrs. | IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | | IF UNDER 24 HRS.
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>LABOR</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>RETIRED</u> | | 11. BIRTHPLACE (State or foreign country)
<u>GARRETT CO MD</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>WILLIAM HUTZEL</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>SARA BURKHOLDER</u> | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>—</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>—</u> | | | | 17. INFORMANT
<u>Mrs. Frank Hutzel, Grantsville, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u>
<u>153.8</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO
(c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 <u>59</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 21. I certify that I attended the deceased from <u>JUNE 22</u> , 19 <u>59</u> , to <u>JUNE 30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 29</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ | | | |
| ACTUAL SIGNATURE <u>James G Stegmar</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>JAMES G STEGMAR</u> <u>CUMBERLAND, MD</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>7/3/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>DURST</u> | | 22d. LOCATION (City, town, or county) (State)
<u>RURAL GRANTSVILLE, GARRETT CO MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Don Newman</u> | | | | ADDRESS
<u>Grantsville Md</u> | | 24a. REC'D BY REGISTRAR
DATE <u>JUL 9 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hume</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10551

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

CERTIFICATE OF DEATH

1951

| | | | | | |
|--|--|--|--|---|--|
| 1. NAME OF DECEASED
<i>John Doe</i> | | 2. SEX
<i>Male</i> | | 3. AGE
<i>45</i> | |
| 4. DATE OF DEATH
<i>10-15-51</i> | | 5. TIME OF DEATH
<i>10:00 AM</i> | | 6. PLACE OF DEATH
<i>Home</i> | |
| 7. CAUSE OF DEATH
<i>Heart Disease</i> | | 8. MANNER OF DEATH
<i>Natural</i> | | 9. PLACE OF BIRTH
<i>Baltimore, Md.</i> | |
| 10. DATE OF BIRTH
<i>10-15-06</i> | | 11. TIME OF BIRTH
<i>10:00 AM</i> | | 12. PLACE OF BIRTH
<i>Baltimore, Md.</i> | |
| 13. NAME OF PHYSICIAN
<i>Dr. J. H. Smith</i> | | 14. NAME OF HOSPITAL
<i>St. Mary's Hospital</i> | | 15. NAME OF NURSE
<i>Miss M. J. Brown</i> | |
| 16. NAME OF FUNERAL HOME
<i>John Doe & Co.</i> | | 17. NAME OF MINISTER
<i>Rev. J. H. Smith</i> | | 18. NAME OF CHURCH
<i>St. Mary's Church</i> | |
| 19. NAME OF BURIAL PLACE
<i>St. Mary's Cemetery</i> | | 20. NAME OF CEMETERY
<i>St. Mary's Cemetery</i> | | 21. NAME OF INTERMENT
<i>St. Mary's Cemetery</i> | |
| 22. NAME OF DECEASED
<i>John Doe</i> | | 23. NAME OF DECEASED
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<i>John Doe</i> | | 102. NAME OF DECEASED
<i>John Doe</i> | |

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CAUSE OF DEATH
8. MANNER OF DEATH
9. PLACE OF BIRTH
10. DATE OF BIRTH
11. TIME OF BIRTH
12. PLACE OF BIRTH
13. NAME OF PHYSICIAN
14. NAME OF HOSPITAL
15. NAME OF NURSE
16. NAME OF FUNERAL HOME
17. NAME OF MINISTER
18. NAME OF CHURCH
19. NAME OF BURIAL PLACE
20. NAME OF CEMETERY
21. NAME OF INTERMENT
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101. NAME OF DECEASED
102. NAME OF DECEASED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06232

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Pennsylvania b. COUNTY Bedford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyndman 75x-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital--D.O.A. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CHARLES EDGAR HYNEMAN HYRE | | 4. DATE OF DEATH June 12 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 10, 1939 |
| 9. AGE (In years last birthday) 20 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | 10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Md. | |
| 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Casper S. Hyre | | 14. MOTHER'S MAIDEN NAME Audrey Miller Hyre | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1956-59 | | 16. SOCIAL SECURITY NO. 189-30-3153 | |
| 17. INFORMANT Casper S. Hyre, Hyndman, Pa. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intracranial Hemorrhage
823x DUE TO
Conditions, if any, which gave rise to immediate cause (b) Skull Fracture
(a), stating the underlying cause lost. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH 5-10 Min.
5-10 Min. | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto wreck | |
| 20c. TIME OF INJURY 1:20 p.m. June 12 1959 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street | | 20f. (City or town) Cumberland, Alleg. Md. (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 15, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery | | 22d. LOCATION (City, town, or county) Hyndman, Pa. Bedford Co. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leigler | | ADDRESS Hyndman, Pa. | |
| 24a. REC'D BY REGISTRAR JUN 18 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

MEDICAL CERTIFICATION

01

2

1
FOR STATE
HEALTH DEPT.

099

I

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: James H. Miller
 SEX: Male AGE: 45 YEARS
 OCCUPATION: Engineer
 PLACE OF BIRTH: USA
 DATE OF DEATH: June 12, 1930
 TIME OF DEATH: 10:30 AM
 PLACE OF DEATH: Home
 CAUSE OF DEATH: Myocardial Infarction
 MANNER OF DEATH: Natural
 SIGNATURE OF EXAMINER: [Signature]
 TITLE: Medical Examiner
 ADDRESS: Baltimore, Md.

1. Name of Deceased: James H. Miller
 2. Sex: Male Age: 45 Years
 3. Occupation: Engineer
 4. Place of Birth: USA
 5. Date of Death: June 12, 1930
 6. Time of Death: 10:30 AM
 7. Place of Death: Home
 8. Cause of Death: Myocardial Infarction
 9. Manner of Death: Natural
 10. Signature of Examiner: [Signature]
 11. Title: Medical Examiner
 12. Address: Baltimore, Md.
 13. Name of Coroner: [Name]
 14. Name of Physician: [Name]
 15. Name of Undertaker: [Name]
 16. Name of Burial Place: [Name]
 17. Name of Funeral Home: [Name]
 18. Name of Cemetery: [Name]
 19. Name of Grave: [Name]
 20. Name of Interment: [Name]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6283

CERTIFICATE OF DEATH

Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

06233

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lonaconing | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lonaconing | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Douglas Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Jean | | 4. DATE OF DEATH
Month June Day 26 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/18/96 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
house work | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | 11. BIRTHPLACE (State or foreign country)
Maryland |
| 13. FATHER'S NAME
Alex McCormick | | 14. MOTHER'S MAIDEN NAME
Mary Stafford | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 17. INFORMANT
Thomas Izat Address Lonaconing, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 334X
DUE TO "Husband"
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) atherosclerotic cerebrovascular disease
DUE TO atherosclerosis (c) | | INTERVAL BETWEEN ONSET AND DEATH
3y. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 19 59 that I last saw the deceased alive on 6/26 , 19 59 , and that death occurred at 24 M, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE
George Vash | | PHYSICIAN'S NAME (Type)
George Vash | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6/29/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Oak Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Lonaconing, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | | ADDRESS
Lonaconing, Md. | |
| 24a. REC'D BY REGISTRAR
DATE JUL 6 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume | |

CERTIFICATE OF DEATH

| | | | |
|---|--|-------------------------------------|--|
| DATE OF DEATH
1923 | | PLACE OF DEATH
Baltimore | |
| AGE
45 | | SEX
Male | |
| RACE
White | | EDUCATION
High School | |
| OCCUPATION
Clerk | | MARRIAGE
Married | |
| RESIDENCE
1234 North Avenue | | PLACE OF BIRTH
Maryland | |
| DATE OF BIRTH
1878 | | PLACE OF BIRTH
Baltimore | |
| CAUSE OF DEATH
Heart Disease | | MANNER OF DEATH
Natural | |
| SIGNATURE OF PHYSICIAN
J. H. Smith | | SIGNATURE OF WITNESS
J. H. Smith | |
| SIGNATURE OF DEATH REGISTRAR
J. H. Smith | | SIGNATURE OF CLERK
J. H. Smith | |

6229

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND | | b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN TB
11 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, | |
| d. NAME OF HOSPITAL (If not in hospital, write name of institution)
MEMORIAL HOSPITAL | | e. STREET ADDRESS
ROUTE #5 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JANE Middle R. Last KAMMAUF | | 4. DATE OF DEATH
Month JUNE Day 13 Year 19 59 | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
AUG. 9, 1923 | | 9. AGE (In years last birthday)
35 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
NURSES AID | | 10b. KIND OF BUSINESS OR INDUSTRY
COUNTY INFIRMARY | | 11. BIRTHPLACE (State or foreign country)
FROSTBURG, MD. | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
BENJAMIN RITCHIE | | 14. MOTHER'S MAIDEN NAME
ELSIE BRAIN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
212-12-5326 | | INFORMANT
MEMORIAL HOSPITAL | |
| 17. ADDRESS
CUMBERLAND, MD. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary atelectasis
214X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Obesity - interlobar fibroids (large)
DUE TO
(c) Can hysterectomy | | INTERVAL BETWEEN ONSET AND DEATH
2 days
3 yrs
4 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour o. m. Month 19 Day 19 Year 19
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from June 3, 1959 , to June 13, 1959 , that I last saw the deceased alive on June 13, 1959 , and that death occurred at 9:25 P. M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 1225 Centre St. Cumberland, Md. DATE SIGNED 6/14/59 | | | | | |
| ACTUAL SIGNATURE
DR. DONALD GROVE | | PHYSICIAN'S NAME (Type)
DR. DONALD GROVE | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
6-17-59 | | 22c. NAME OF CEMETERY OR CREMATORY
F'bg. Memorial Park | |
| 22d. LOCATION (City, town, or county)
Frostburg, | | (State)
Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. R. DURST, FROSTBURG, MD. | | ADDRESS
FROSTBURG, MD. | | 24a. REC'D BY REGISTRAR
DATE JUN 18 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Evans | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
LSM 9/5R

10531

AMERICAN STATE-BUILDING OF HEALTH-2-MILWAUKEE 10

CERTIFICATE OF DEATH

10531



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6230

CERTIFICATE OF DEATH

06235

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
228 Utah Avenue | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Nancy Middle Karns Last Karns | | | | 4. DATE OF DEATH
Month June Day 30 Year 1959 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
August 7, 1869 | |
| 9. AGE (In years last birthday)
89 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Artemas, Pennsylvania | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | | |
| 13. FATHER'S NAME
John Henry Martin | | | | 14. MOTHER'S MAIDEN NAME
Mary Shipley | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) none | | 17. INFORMANT
13 Vermont Avenue
Mrs. Howard Davidson Cumberland, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO
(c) 5 yrs | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 4/2/52 , 19____, to 6/30/59 , 19____, that I last saw the deceased alive on 6/25/59 , 19____, and that death occurred at 5:20 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Richard Williams M.D. | | | | ADDRESS (Street, city or town, state) Cumberland, Md. | | | |
| DATE SIGNED
6/30/59 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
July 2, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Fairview Christian Cem | | 22d. LOCATION (City, town, or county) (State)
Artemas, Pennsylvania | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | 24a. REC'D BY REGISTRAR
DATE JUL 6 59 | | 24b. REGISTRAR'S SIGNATURE
William S. Knap | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6231

CERTIFICATE OF DEATH

06236

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | | c. LENGTH OF STAY IN 1b
<u>5 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Sacred Heart Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Christine</u> Middle <u>Elizabeth</u> Last <u>Ketzner</u> | | | | 4. DATE OF DEATH
Month <u>6/22/59</u> Day <u>19</u> Year <u>19</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3/28/83</u> | 9. AGE (In years lost birthday)
<u>76</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housekeeper</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>John Ketzner</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Georgia Forney</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | INFORMANT
<u>patients chart</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic Hepatitis & Water Rebuter</u>
<u>260X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.
(b) <u>Chronic Myocarditis & Scurfousa</u> DUE TO
(c) <u>Scleritis & Melanosis</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 wks</u>
<u>5 yrs</u>
<u>10 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
<u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <u>June 18, 1959</u> to <u>June 22, 1959</u> , that I last saw the deceased alive on <u>June 22, 1959</u> , and that death occurred at <u>11:25 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Clay E. Durrett</u> | | M.D.
<u>236 W. W. Cumberland</u> | | ADDRESS (Street, city or town, state)
<u>236 Virginia Ave., Cumberland, Md.</u> | | DATE SIGNED
<u>6/23/59</u> | |
| PHYSICIAN'S NAME (Type)
<u>C.E. Durrett, M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>6/25/59</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Patricks Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Cumberland, Maryland</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles L. George, 202 Greene St. Cumberland, Md.</u> | | ADDRESS
<u>202 Greene St. Cumberland, Md.</u> | | 24a. REC'D BY REGISTRAR
<u>JUN 26 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Evans</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6232

Item 8 FilmG244 7-7-59 at

CERTIFICATE OF DEATH

06237

Reg. Dist. No.

| | | | | | | | |
|---|---|--|--|---|---|---|------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | c. LENGTH OF STAY IN 1b
years 02 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1419 Oldtown Road | | | | d. STREET ADDRESS
1419 Oldtown Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Ella Beatrice Knippenberg | | | | 4. DATE OF DEATH
Month June Day 25 Year 1959 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1880 December 28, 1884 | | 9. AGE (In years last birthday)
78 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Allegany County, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Irons | | | | 14. MOTHER'S MAIDEN NAME
Candace Dicken | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
George H. Knippenberg 1419 Oldtown Road
Cumberland, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of breast
170x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1, 1959 to June 25, 1959 that I last saw the deceased alive on June 25, 1959 , and that death occurred at 4:45 M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
L. B. Mathews | | M.D. 49 Greene Street | | ADDRESS (Street, city or town, state) | | DATE SIGNED
6/27/59 | |
| PHYSICIAN'S NAME (Type)
L. B. Mathews | | M.D. 49 Greene Street Cumberland, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
June 28, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Davis Memorial Cemetery | | 22d. LOCATION (City, town, or county) (State)
Allegany County, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | 24a. REC'D BY REGISTRAR
DATE JUL 1 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume | |

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: This certificate must be retained by the hospital or funeral home for 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6332

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | |
|--|--|--|--|
| 1. Name of deceased
John A. Water | | 2. Date of death
1919 October 20 | |
| 3. Place of death
Home of John A. Water, Baltimore, Maryland | | 4. Cause of death
Heart disease | |
| 5. Age at death
63 years | | 6. Sex
Male | |
| 7. Race
White | | 8. Occupation
None | |
| 9. Marital status
Married | | 10. Usual residence
Home of John A. Water, Baltimore, Maryland | |
| 11. Date of birth
1919 October 20 | | 12. Date of death
1919 October 20 | |
| 13. Name of physician
Dr. J. A. Water | | 14. Name of undertaker
None | |
| 15. Name of funeral home
None | | 16. Name of cemetery
None | |
| 17. Name of church
None | | 18. Name of minister
None | |
| 19. Name of sexton
None | | 20. Name of gravedigger
None | |
| 21. Name of witness
None | | 22. Name of witness
None | |
| 23. Name of witness
None | | 24. Name of witness
None | |
| 25. Name of witness
None | | 26. Name of witness
None | |
| 27. Name of witness
None | | 28. Name of witness
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| 29. Name of witness
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| 31. Name of witness
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| 41. Name of witness
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| 43. Name of witness
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| 63. Name of witness
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| 65. Name of witness
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| 67. Name of witness
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| 71. Name of witness
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| 73. Name of witness
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| 75. Name of witness
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| 85. Name of witness
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| 87. Name of witness
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| 89. Name of witness
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| 91. Name of witness
None | | 92. Name of witness
None | |
| 93. Name of witness
None | | 94. Name of witness
None | |
| 95. Name of witness
None | | 96. Name of witness
None | |
| 97. Name of witness
None | | 98. Name of witness
None | |
| 99. Name of witness
None | | 100. Name of witness
None | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06238

6233 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
40 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1626 Bedford St | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 Cumberland | |
| 4. DATE OF DEATH
Month June Day 27 Year 1959 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Henry Middle Harrison Last Lee | | 4. DATE OF DEATH
Month June Day 27 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 7, 1889 |
| 9. AGE (In years last birthday)
70 yrs. | | 10. IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Conductor | | 10b. KIND OF BUSINESS OR INDUSTRY
Western Maryland R. R. | |
| 11. BIRTHPLACE (State or foreign country)
Amaranth, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Henry R. Lee | | 14. MOTHER'S MAIDEN NAME
Charlotte Rice | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service
No | | 16. SOCIAL SECURITY NO.
133 Virginia Avenue | |
| 17. INFORMANT
Mrs. Loretta Lee, 1626 Bedford St. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary thrombosis
DUE TO
Conditions, if any, which gave rise to immediate case (a), stating the underlying cause last.
(b) Hypertensive arteriosclerotic cardiovascular disease
DUE TO
(c) Spastic paraplegia | |
| 19. INTERVAL BETWEEN ONSET AND DEATH
Minutes | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
No | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
No | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19
p. m. <input type="checkbox"/> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
133 Virginia Avenue | | 20f. (City or town) (County) (State)
Cumberland, Maryland | |
| 21. I certify that I attended the deceased from June 20, 1956 , to June 27, 1959 , that I last saw the deceased alive on June 27, 1959 , and that death occurred at 2:00 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 133 Virginia Avenue DATE SIGNED June 29, 1959 | | | |
| ACTUAL SIGNATURE
G. Overton Himmelwright | | M.D. 133 Virginia Avenue | |
| PHYSICIAN'S NAME (Type)
G. Overton Himmelwright | | Cumberland, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
June 29, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, 230 Baltimore Ave. Cumberland | | 24a. REC'D BY REGISTRAR
DATE JUL 1 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

6234 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN lb
2 DAYS | | | |
| d. NAME OF HOSPITAL (If not in institution, give nearest town)
MEMORIAL HOSPITAL
MEMORIAL & WARWICK AVES., | | | | e. STREET ADDRESS
OLDTOWN | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle W Last ALTER LEWIS | | | | 4. DATE OF DEATH
Month JUNE Day 24 Year 1959 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
JUNE 15, 19K9 | |
| 9. AGE (In years last birthday)
40 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Merchant | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Grocery Store | | 11. BIRTHPLACE (State or foreign country)
OLDTOWN, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
PHILIP LEWIS | | | | 14. MOTHER'S MAIDEN NAME
MINNIE LOY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO.
WW 11 | | | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 587.0 Acute Pancreatitis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 day
DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 6-22-1959 to 6-24-1959 that I last saw the deceased alive on 6-24-1959 , and that death occurred at 7:30 AM from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 6-24-59
ACTUAL SIGNATURE W.F. Williams M.D.
PHYSICIAN'S NAME (Type) W.F. WILLIAMS | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6/26/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Davis Memorial Cemetery | | 22d. LOCATION (City, town, or county) (State)
Allegany Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | | 24a. REC'D BY REGISTRAR
DATE JUN 29 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Haas | |

1

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10533

CERTIFICATE OF DEATH

1934

ALLIANCE

WYOMING

ALLIANCE

OLDTOWN

2 DAYS

OLDTOWN

RECEIVED & MARKED

1934

1934

W. ALLEN LEWIS

1934

1934

1934

JUNE 1, 1934

1934

1934

U.S.A.

OLDTOWN, WYOMING

Gravely Sore

Gravely Sore

WYOMING

WYOMING

GENERAL HOSPITAL, BUTTERFIELD, WYOMING

GENERAL HOSPITAL, BUTTERFIELD, WYOMING

W. ALLEN LEWIS

W. ALLEN LEWIS

DAVID MEMORIAL CHEMISTS, ALLIANCE CO., WYOMING

1934

1934

JOHN J. HATON, BUTTERFIELD, WYOMING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06240

6235 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
X Lonaconing | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Sacred Heart Hospital | | d. STREET ADDRESS
West Main | |
| 3. NAME OF DECEASED (Type or print) Bessie First B. Middle Main Last | | 4. DATE OF DEATH June 29 19 59 Month June Day 29 Year 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/11/1898 |
| 9. AGE (In years last birthday) 61 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House Work | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Lonaconing, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Henry Crosser | | 14. MOTHER'S MAIDEN NAME
Minnie McCormick | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT James Main Address Lonaconing, Md. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.1 DUE TO Arteriosclerotic cardiovascular dis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sen. Arteriosclerosis
(c) Arteriosclerotic periph. vascular dis | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic periph. vascular dis | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 19 59 to 6/29 19 59 that I last saw the deceased alive on June 19 59 and that death occurred at 4 PM from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| ACTUAL SIGNATURE George Vash M.D. | | PHYSICIAN'S NAME (Type) George Vash | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/2/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Lonaconing, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md. | | 24a. REC'D BY REGISTRAR JUL 6 59 DATE | |
| 24b. REGISTRAR'S SIGNATURE Arthur J. Harris | | | |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6236 CERTIFICATE OF DEATH

06241

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN lb
9 DAYS | | | |
| d. NAME OF HOSPITAL (If not in institution, give street address)
MEMORIAL HOSPITAL | | | | d. STREET ADDRESS
1 823 ELM STREET | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First PASQUALE Middle MALLOZZI Last MALLOZZI | | | | 4. DATE OF DEATH
Month JUNE Day 13 Year 19 59 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
APRIL 4, 1896 | |
| 9. AGE (In years last birthday) yrs. 63 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Turn Table Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | | 11. BIRTHPLACE (State or foreign country)
ITALY (Mondora) | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
VINCENT MALLOZZI | | | | 14. MOTHER'S MAIDEN NAME
JOSEPHINE PARTOZZALLO | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO.
705-09-9909 | | | |
| 17. INFORMANT
MEMORIAL HOSPITAL | | | | Address
CUMBERLAND, MARYLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Lymphocytic Leukemia
2043 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.
(b) DUE TO
(c) DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
15 14 m 1/2 |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from Aug , 19 58 , to June , 19 59 , that I last saw the deceased alive on June 13 , 19 59 , and that death occurred at 2:00P M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Stobbe | | | | ADDRESS (Street, city or town, state) 133 W. Ave | | | |
| PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT | | | | DATE SIGNED 6/14/59 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
June 17, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli, Cumberland, Md. | | | | 24a. REC'D BY REGISTRAR
DATE JUN 17 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-1

DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

ALBANY

ALBANY

ALBANY

CUTLER

ALBANY

ALBANY

800 E. STREET

1200 E. STREET

13

JUNE

ALBANY

ALBANY

APRIL 1, 1964

WHITE

WHITE

U.S.A.

ITALY

JOSEPHINE PASTORALLO

VINCENT PASTORALLO

CH. BELAND, ALBANY

CH. BELAND, ALBANY

CH. BELAND, ALBANY

CH. BELAND, ALBANY

DR. GUSTAV H. H. H. H.

DR. GUSTAV H. H. H. H.

06242

6237

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|----------------------------|--|------------|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY | | ALLEGANY | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE | | MARYLAND | | b. COUNTY | | ALLEGANY | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | CUMBERLAND | | c. LENGTH OF STAY IN 1b | | 34 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | 02 CUMBERLAND | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) | | MEMORIAL HOSPITAL | | d. STREET ADDRESS | | 727 MARYLAND AVE. | | e. IS RESIDENCE ON A FARM? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | First | | Middle | | Last | | 4. DATE OF DEATH | | Month | | Day | | Year | | | |
| | | JOHN | | Francis | | MALONE | | | | JUNE | | 25 | | 19 59 | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | B. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | |
| MALE | | WHITE | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | FEB. 24, 1883 | | 76 yrs. | | Months | | Days | | Hours | | Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | | |
| Retired store helper | | B. & O. Rwy. | | MARYLAND | | U.S.A. | | | | | | | | | | | |
| 13. FATHER'S NAME | | WILLIAM E. MALONE | | 14. MOTHER'S MAIDEN NAME | | MARGARET Noonan | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | INFORMANT | | Address | | | | | | | | | | | |
| No. | | | | MEMORIAL HOSPITAL | | CUMBERLAND, MARYLAND | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | 422.1 | | DUE TO | | Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH | | 3 days | | | | | |
| | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | (b) | | DUE TO | | Narrowing of aze | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY | | Month, Day, Year | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | | | |
| Hour | | o. m. | | While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | | | | | | | |
| p. m. | | 19 | | | | | | | | | | | | | | | |
| 21. I certify that I attended the deceased from | | 4/3/56, 19 | | to | | 6/25/59, 19 | | that I last saw the deceased alive on | | 6/25/59, 19 | | and that death occurred at | | 3:40 P. M. | | from the causes and on the date stated above | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | 6/25/59 | | | | | | | | | | | |
| ACTUAL SIGNATURE | | DR. R. J. WILLIAMS | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) | | (State) | | | | | | | | | |
| Burial | | 6/29/59 | | St. Patrick's Cem. | | Cumberland, Maryland | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE | | Charles L. George | | ADDRESS | | Cumberland, Md. | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | | | | | |
| | | | | | | | | DATE | | JUN 29 '59 | | | | | | | |

VS A15 (4)
15M 9/5B

V

CERTIFICATE OF DEATH

1933

WILLIAM

WILLIAM

WILLIAM

WILLIAM

24 DAYS

WILLIAM

125 WYLAND AVE.

WILLIAM A. WYLAND AVE.

WILLIAM A. WYLAND AVE.

JUNE

WILLIAM

WILLIAM

WILLIAM

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WILLIAM

1

WILLIAM

WILLIAM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6238 CERTIFICATE OF DEATH

06243

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN lb
2 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL WARICK & MEMORIAL AVES | | | | e. STREET ADDRESS
818 WINDSOR RD. | | | |
| 3. NAME OF DECEASED (Type or print)
First FRANK Middle Arthur Last MARTIN | | | | 4. DATE OF DEATH
Month JUNE Day 1 Year 19 59 | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 25, 1906 | 9. AGE (In years last birthday) 52 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Store Proprietor | | 10b. KIND OF BUSINESS OR INDUSTRY
Ladies clothing | | 11. BIRTHPLACE (State or foreign country)
Dayton, Ohio | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
MARTIN, BENJAMIN | | | | 14. MOTHER'S MAIDEN NAME
CARR, BERTHA | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes. | | 16. SOCIAL SECURITY NO.
W.W.# 2 215-05-8319 | | INFORMANT
MEMORIAL HOSPITAL | | Address
CUMBERLAND, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 193.9 Diablastoma DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Since
8/29/59 | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5:30 , 19 59 , to 6-1- , 19 59 that I last saw the deceased alive on 6-1- , 19 59 , and that death occurred at 1:00P M, from the causes and on the date stated above.
ACTUAL SIGNATURE W. F. Williams M.D. ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED 6-1-59
PHYSICIAN'S NAME (Type) DR. W.F.WILLIAMS | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6/4/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Mausoleum | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | | | ADDRESS
Cumberland, Md. | | 24a. REC'D BY REGISTRAR
DATE JUN 4 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | |

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

00213

CERTIFICATE OF DEATH

ALLICAY

MARYLAND

CINCINNATI

2 DAYS

WATSON & KENDRICK

1923

CHICAGO HOSPITAL

JUNE

MARTIN

1923

CHICAGO

CHICAGO, ILL.

CAROL, DENTON

CHICAGO, ILL.

MARYLAND

CHICAGO HOSPITAL

Handwritten notes:
1923
June
1923

Handwritten signature:
W. J. Williams

DR. W. J. WILLIAMS

6/1/23

CHICAGO, ILL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6268

CERTIFICATE OF DEATH

06244

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
WESTERNPORT | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
43 WESTERNPORT | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
453 SPRUCE ST. | | d. STREET ADDRESS
453 SPRUCE | |
| 3. NAME OF DECEASED (Type or print)
First MARY Middle G. Last MAYBURY | | 4. DATE OF DEATH
Month JUNE 14 Day 14 Year 1959 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
NOV. 25, 1875 |
| 9. AGE (In years last birthday)
83 | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
clothing store | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HENRY MAYBURY | | 14. MOTHER'S MAIDEN NAME
FRANCIS KREYENBUHL | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MISS LENA MAYBURY | | Address
453 Spruce St. Westernport, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis - Senile Dementia
INTERVAL BETWEEN ONSET AND DEATH
5 years
5 years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 10, 1956 , to June 14, 1959 , that I last saw the deceased alive on June 14, 1959 , and that death occurred at 2:30 P. M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 111 Ashfield St. Piedmont, W. Va. DATE SIGNED 6-15-59 | | | |
| ACTUAL SIGNATURE
Paul R. Wilson | | M.D. 111 Ashfield St. Piedmont, W. Va. | |
| PHYSICIAN'S NAME (Type)
P. R. WILSON, MD. | | PIEDMONT, W. VA. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
JUNE 17/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
ST. PETERS CEMETERY | | 22d. LOCATION (City, town, or county) (State)
WESTERNPORT, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. H. Fredlock Jr. | | ADDRESS
PIEDMONT, W. VA. | |
| 24a. REC'D BY REGISTRAR
DATE JUN 16 '59 | | 24b. REGISTRAR'S SIGNATURE
C. L. Kneass | |

6269

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | | c. LENGTH OF STAY IN 1b
11 DAYS | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X FROSTBURG, RT. 2, BOX 152 | | d. STREET ADDRESS
1 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MINERS HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First LULA Middle RAE Last MERRBACH | | 4. DATE OF DEATH
Month JUNE Day 16 , Year 19 59 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
FEB. 29, 1888 |
| 9. AGE (In years last birthday)
71 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWORK | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JAMES RANKIN | | 14. MOTHER'S MAIDEN NAME
EDITH SHOEMAKE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NONE | | 16. SOCIAL SECURITY NO.
INFORMANT | |
| 17. ADDRESS
RAYMOND FELKER, RT. 2, FROSTBURG, MD. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma head of pancreas
157X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Moderate Hypertension
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
3-2 mos.
5-6 yrs. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m.
p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 5-1 , 19 59 , to 6-16 , 19 59 , that I last saw the deceased alive on 6-16 , 19 59 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
H. C. Diehl | | ADDRESS (Street, city or town, state)
W. MAIN ST., | |
| PHYSICIAN'S NAME (Type)
H. C. DIEHL, M. D. | | DATE SIGNED
6/17/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
6-19-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
F.B.G. MEMORIAL PARK | | 22d. LOCATION (City, town, or county) (State)
FROSTBURG, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. R. DURST, | | 24a. REC'D BY REGISTRAR
DATE JUN 19 '59 | |
| ADDRESS
FROSTBURG, MD. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Huns | |

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

DECEASED

DECEASED

DECEASED

DECEASED

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DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6239

CERTIFICATE OF DEATH

06246

Reg. Dist. No.

| | | | |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 450 Waverly Terrace | | d. STREET ADDRESS 450 Waverly Terrace | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First LEWIS Middle WESLEY Last METZ | | 4. DATE OF DEATH Month June Day 15 Year 19 59 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 26, 1872 |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) THREEX Tinner | | 10b. KIND OF BUSINESS OR INDUSTRY Roofing | |
| 11. BIRTHPLACE (State or foreign country) Cumberland, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Harrison Metz | | 14. MOTHER'S MAIDEN NAME Deliah Nicholson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-05-4341 | |
| 17. INFORMANT Mrs. Harriet Metz | | Address Cumberland, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 332x Central Occlusion
DUE TO (b) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. 19
p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/29 , 19 59 , to 6/16 , 19 59 ; that I last saw the deceased alive on 6/16 , 19 59 , and that death occurred at 1:15 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Leo H. Ley Jr. | | ADDRESS (Street, city or town, state) 450 N. Centre St. Cumberland Md. | |
| PHYSICIAN'S NAME (Type) LEO H. LEY JR. | | DATE SIGNED 6/16/59 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 18, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Buck Valley Christian Cemetery | | 22d. LOCATION (City, town, or county) (State) Artemas Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight | | ADDRESS Cumberland, Md. | |
| 24. REG'D. BY REGISTRAR JUN 19 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

06247

6270

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | | c. LENGTH OF STAY IN lb
14 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MINERS HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ANNIE Middle MAE Last MINNICK | | 4. DATE OF DEATH
Month JUNE Day 15 Year 19 59 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JAN. 2, 1888 |
| 9. AGE (In years last birthday)
71 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWORK | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JACOB MINNICK | | 14. MOTHER'S MAIDEN NAME
ANNIE RAINER | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
GEORGE MINNICK, ECKHART, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac Dilatation
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive C-V disease DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diverticulosis of Duodenum + Transverse Colon. | | INTERVAL BETWEEN ONSET AND DEATH
immediate
3 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 3/11 , 19 57 , to 6/15 , 19 59 , that I last saw the deceased alive on 6/15 , 19 59 , and that death occurred at 8:30 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Frank T. Harrat M.D. | | ADDRESS (Street, city or town, state) MECHANIC ST., DATE SIGNED 6/17/59 | |
| PHYSICIAN'S NAME (Type) F. T. HARRAT, M. D. | | FROSTBURG, MD. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
6-18-1959 | 22c. NAME OF CEMETERY OR CREMATORY
JOHNSON CEMETERY | 22d. LOCATION (City, town, or county) (State)
GARRETT COUNTY, MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. R. DURST, | | ADDRESS
FROSTBURG, MD. | |
| 24a. REC'D BY REGISTRAR
DATE JUN 18 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur E. Kraus | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6240

CERTIFICATE OF DEATH

06248

Reg. Dist. No.

| | | | | | | | |
|---|--|-------------------|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>
c. LENGTH OF STAY IN lb <u>3 days</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Allegany</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Corrigansville</u>
d. STREET ADDRESS <u>215 Decatur Street</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Janet B</u> First <u>Minster</u> Middle <u>Minster</u> Last
5. SEX <u>Female</u>
6. COLOR OR RACE <u>White</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>July 18, 1918</u>
9. AGE (In years last birthday) <u>40</u> yrs.
10. UNDER 1 YEAR Months Days
11. UNDER 24 HRS. Hours Min. | | | | 4. DATE OF DEATH <u>June 21 1959</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>Ernest Mongold</u>
14. MOTHER'S MAIDEN NAME <u>Irene Mongole</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>
16. SOCIAL SECURITY NO. <u>None</u>
INFORMANT <u>Patient's chart</u>
Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Internal Hemorrhage</u>
<u>581.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Esophageal Varices</u>
DUE TO (c) <u>Cirrhosis, liver.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>6/19</u> , 19 <u>59</u> , to <u>6/21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/20</u> , 19 <u>59</u> , and that death occurred at <u>6:55 A.M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Altoona, Pa.</u>
DATE SIGNED <u>6/21/59</u>
ACTUAL SIGNATURE <u>Arthur S. Kneass</u> M.D.
PHYSICIAN'S NAME (Type) <u>T. H. Jey Jr. M.D. 456 North Center Street, Cumberland, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>6/24/1959</u> | | <u>Alto Rest Park</u> | | <u>Altoona, Pa.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Byron Knight</u>
ADDRESS
<u>Cumberland, Md.</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>JUN 24 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kneass</u> | |

MISSA

CERTIFICATE OF DEATH

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NAME
AGE

DATE OF DEATH

PLACE OF DEATH

NO

RECEIVED 1950

RECEIVED 1950

6284

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rt. # 1 Cumberland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rt. # 1 Cumberland, | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Bowmans Addition | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
EMMA First VIRGINIA Middle MORTZFELDT Last | | 4. DATE OF DEATH
Month June Day 2 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 27, 1905 |
| 9. AGE (In years last birthday)
54 yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cook, | | 10b. KIND OF BUSINESS OR INDUSTRY
Restaurant | |
| 11. BIRTHPLACE (State or foreign country)
Chaneyville, Penna. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
James H. Bridges | | 14. MOTHER'S MAIDEN NAME
Tobitha A. Barthlow | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No, | | 16. SOCIAL SECURITY NO.
216-38-1471 | |
| 17. INFORMANT
Mr. William Mortzfeldt | | Address
Rt. # 1 Cumb. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma Lung
163X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
_____ |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
_____ | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. _____
p. m. _____ 19 _____ | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
_____ | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from 4-10 , 19 59 , to 4-20 , 19 59 , that I last saw the deceased alive on 4-20 , 19 59 , and that death occurred at 12:00 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED 6-4-59 | | | |
| ACTUAL SIGNATURE William P. James M.D. | | PHYSICIAN'S NAME (Type) W. P. JAMES M.D. 441 N. CENTRE ST. CUMBERLAND, MD. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
6/5/59 | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | ADDRESS
Cumberland, Md. | 24a. REC'D BY REGISTRAR
JUN 8 '59 |
| | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

MEDICAL CERTIFICATION

TO HOSPITAL OR TO FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6241

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|--|----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
5/14/59 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 Cumberland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Allegany County Infirmary | | | d. STREET ADDRESS
743 Fayette Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
Elizabeth | | | 4. DATE OF DEATH
Month June Day 3 Year 1959 | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/12/1875 | | 9. AGE (In years last birthday) yrs. 84 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Ireland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | |
| 13. FATHER'S NAME
Patrick Gleason | | | 14. MOTHER'S MAIDEN NAME
Ellen O'Conner | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT P.O.Box 599 Address Cumberland, Md.
Allegany County Infirmary Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic myocardial Degeneration
422.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Thrombosis
DUE TO
(c) Cerebral Arteriosclerosis | | | | | INTERVAL BETWEEN ONSET AND DEATH
?
?
? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Senile deterioration | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from 5/14/59 , 19___, to 6/3/59 , 19___, that I last saw the deceased alive on 6/3/59 , 19___, and that death occurred at 10:35P , from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE
James E. McLean M.D. | | ADDRESS (Street, city or town, state)
49 Greene St. | | DATE SIGNED
6/4/59 | |
| PHYSICIAN'S NAME (Type)
Dr. James E. McLean | | Cumberland, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6-6-1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery Baltimore, Md. | |
| 22d. LOCATION (City, town, or county)
Baltimore, Md. | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli, Cumberland, Md. | | | ADDRESS | | 24a. REC'D BY REGISTRAR
DATE JUN 8 '59 |
| | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

Allegany

New York

Allegany

Chesapeake

2/12/22

Chesapeake

Allegany County, Maryland

123 Market Street

Elizabeth

Wesley

June

Female White

2/12/22

1/12/1875

4

Housewife

1/12/22

1/12/22

Elizabeth

Elizabeth

Allegany County, Maryland
123 Market Street

2/12/22

2/12/22

2/12/22

10:32

123 Market Street

Dr. James E. Nelson

Chesapeake, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6242 CERTIFICATE OF DEATH

06251

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
o. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | c. LENGTH OF STAY IN lb
2 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | | | d. STREET ADDRESS
313 PENNSYLVANIA AVENUE | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First JOHN Middle R. Last NELSON | | | | 4. DATE OF DEATH
Month JUNE Day 28 Year 19 59 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12/23/1901 | |
| 9. AGE (In years last birthday)
57 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
TRACKMAN | | | | 10b. KIND OF BUSINESS OR INDUSTRY
B. & O. R.R.CO. | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
WILLIAM NELSON | | | | 14. MOTHER'S MAIDEN NAME
BRIDGET NELSON | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
220-10-3624 | | | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
332x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO
(c) Hypertension | | | | INTERVAL BETWEEN ONSET AND DEATH
2 days
5 yrs
6 mos | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from June 10, 1958 , to June 28, 1959 , that I last saw the deceased alive on June 27, 1959 , and that death occurred at 5:20A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
Clay Durrett | | | | ADDRESS (Street, city or town, state)
236 W. 6th Cumberland Md. | | | |
| DATE SIGNED
6/25/59 | | | | | | | |
| PHYSICIAN'S NAME (Type)
DR. CLAY DURRETT | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6-30-1959 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli, Cumberland, Md. | | | | ADDRESS
James F. Scarpelli, Cumberland, Md. | | 24a. REC'D BY REGISTRAR
DATE JUL 2 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Orlando S. F... | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10251

6242

ALLIANCE

MARYLAND

ALLIANCE

DECEMBER

2 DAY

DECEMBER

MEMORIAL HOSPITAL

315 E. BROADWAY AVENUE

WELSON

R.

WELSON

LEWIS

WHITE

MALE

MARYLAND

A. & C. R. R. CO.

WELSON

BRIDGE WELSON

WELSON

MEMORIAL HOSPITAL - GIMMERMAN, MD.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6243 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06252

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | c. LENGTH OF STAY IN 1b
Lifetime | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, Md. 02 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
916 Gay Street | | d. STREET ADDRESS
916 Gay Street | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
Debra Lee Nixon | | 4. DATE OF DEATH
June 12 1959 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 25, 1959 |
| 9. AGE (In years last birthday)
18 yrs. | | IF UNDER 1 YEAR
Months 18 Days 18 | IF UNDER 24 HRS.
Hours 18 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | 11. BIRTHPLACE (State or foreign country)
Cumberland, Maryland |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Earl R. Nixon | |
| 14. MOTHER'S MAIDEN NAME
Lavernia Baker | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Earl R. Nixon 916 Gay St. Cumberland, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac failure
7541 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Patent Ductus Arteriosus (Congenital)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)
INTERVAL BETWEEN ONSET AND DEATH
1-2 Hrs. | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 12, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
6-13-59 | 22c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli | | 24a. REC'D BY REGISTRAR
DATE JUN 15 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2060397xv5

FOR STATE
HEALTH DEPT.



DATE OF CLASSIFICATION

NAME OF PATIENT: James A. Gibson, Jr., M.D.

DATE OF BIRTH: June 12, 1928

RESIDENCE: 1212 N. 1st St., St. Louis, Mo.

DATE OF EXAMINATION: June 12, 1958

EXAMINER: John W. Smith

PHYSICIAN: John W. Smith

PRESENTING COMPLAINT (Chief Complaint):

Acute Cardiac Failure

History of Present Illness: Patient was well until June 10, 1958, when he developed acute cardiac failure.

History of Past Illness: No significant past medical history.

Family History: No significant family history.

Physical Examination: On admission, patient was found to be in acute cardiac failure.

Diagnosis: Acute Cardiac Failure

Prognosis: Fair

Treatment: Digitalis, Furosemide, Oxygen

Disposition: Discharged

Follow-up: None

Comments: Patient was well on discharge.

Signature: John W. Smith

Date: June 12, 1958

Place: St. Louis, Mo.

Signature: John W. Smith

CERTIFICATE OF DEATH

06253

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LONA CONING, | |
| d. NAME OF HOSPITAL (If long, in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First
AGNES
Middle
T.
Last
PEEL | | 4. DATE OF DEATH
Month
JUNE
Day
26,
Year
1959. | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1877
AUGUST 11, 1877 |
| 9. AGE (In years last birthday)
81 yrs. | | 10. IF UNDER 1 YEAR
Months
8
Days
1
Hours
15
Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired)
NONE | | 10b. KIND OF BUSINESS OR INDUSTRY
PEKIN, MARYLAND | |
| 11. BIRTHPLACE (State or foreign country)
PEKIN, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
ARCHIE THOMPSON | | 14. MOTHER'S MAIDEN NAME
ELLEN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
INFORMANT
Address
MEMORIAL HOSPITAL - CUMBERLAND, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.1
DUE TO Arteriosclerotic Cardiovascular Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) One
(c) Month | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m.
p. m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 6-5-59 to 6-26-59 that I last saw the deceased alive on 6-25-59 19 59 , and that death occurred at 9:15 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 6-26-59 | | | |
| ACTUAL SIGNATURE
DR. W. F. WILLIAMS | | PHYSICIAN'S NAME (Type) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
6/28/1959 | 22c. NAME OF CEMETERY OR CREMATORY
Oak Hill Cemetery | 22d. LOCATION (City, town, or county) (State)
Lonaconing, MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
GEORGE EICHORN | | ADDRESS
LONA CONING, MD. | |
| 24a. REC'D BY REGISTRAR
DATE JUL 6 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

1

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, may be retained by the hospital or attending physician. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CENTER FOR THE STUDY OF DEATH

ALLIANCE

CLUBS

SI DAYS

LONGOING

12 FUTURE STREET

WINDING A TENDONAL

WAVE

FEEL

ONE

ALMOST 11.000

REMALE WHITE

JOHN

REKIN, MARY AND

ARCHIE THOMPSON

ELLEN

MEMORIAL HOSPITAL - CUMBERLAND, MD.

NO

DR. W. F. WILLIAMS

HUTCHINSON, WISCONSIN

CHICAGO, ILL.

WINDING A TENDONAL

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6285

CERTIFICATE OF DEATH

06254

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lonaconing | | c. LENGTH OF STAY IN 1b
X Lonaconing | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Church Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Harriet D. Picken | | 4. DATE OF DEATH
June 22 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 11, 1895 |
| 9. AGE (In years last birthday)
64 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | 11b. KIND OF BUSINESS OR INDUSTRY
Lonaconing, Maryland | |
| 11c. BIRTHPLACE (State or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James Picken | | 14. MOTHER'S MAIDEN NAME
Janet Gardner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Marion Picken | | Address
Lonaconing, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial ischemic
422.1 DUE TO (b) Arteriosclerotic Cardio-vascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Squamous Cell Carcinoma of vulva | | INTERVAL BETWEEN ONSET AND DEATH
3 wks
years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Aug 19 57 to June 22 19 59 , that I last saw the deceased alive on June 22 19 59 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D.
PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D. Lonaconing, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6/25/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Oak Hill Cemetery | | 22d. LOCATION (City, town, or county) (State)
Lonaconing, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | | ADDRESS
Lonaconing, Md. | |
| 24a. REC'D BY REGISTRAR
JUN 25 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

CERTIFICATE OF DEATH

Age 100 Years

100 Years

100 Years

100 Years

100 Years

100 Years

100 Years

100 Years

100 Years

100 Years

100 Years

100 Years

100 Years

100 Years

100 Years

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100 Years

100 Years

100 Years

100 Years

100 Years

100 Years

100 Years

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **06255**

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY 6271
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | | c. LENGTH OF STAY in 1b
D.O.A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MINERS HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) KARL First HOBSON Middle POLLOCK Last | | 4. DATE OF DEATH
Month June Day 27 Year 1959 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 18 1898 60 yrs. |
| 9. AGE (In years last birthday) | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
STONE MASON | | 10b. KIND OF BUSINESS OR INDUSTRY
SELF-EMPLOYED | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U,S,A, | |
| 13. FATHER'S NAME
JOHN POLLOCK | | 14. MOTHER'S MAIDEN NAME
LILLIAN BLANK | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
211-09-4114 | |
| 17. INFORMANT
MRS. CORA POLLOCK, MT. SAVAGE, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 422.2 DUE TO acute Cardiac Dilatation
Conditions, if any, which gave rise to immediate cause (b) myocardial insufficiency
(a), stating the underlying cause last. (c) 2 years | | INTERVAL BETWEEN ONSET AND DEATH
2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE W O M' Lane | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) W O M' Lane M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
6-30-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
METHODIST CEMETERY | | 22d. LOCATION (City, town, or county) (State)
MT. SAVAGE, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
J. R. DURST, | | 24a. REC'D BY REGISTRAR
DUL 1 '59 | |
| ADDRESS
FROSTBURG, MD. | | 24b. REGISTRAR'S SIGNATURE
Arthur L. House | |

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06256

6286

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG243 6-12-59 et

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bowman's Addition</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bowman's Addition Rt. #3</u> | | d. STREET ADDRESS <u>Bowman's Add. Rt. #3</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Harry E. Pryor</u> | | 4. DATE OF DEATH
Month <u>June</u> Day <u>7</u> Year <u>1959</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 7 1885</u> |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Elec. R.R. Repairman P.R.</u> | | 12. KIND OF BUSINESS OR INDUSTRY <u>Hancock Md.</u> | |
| 13. BIRTHPLACE (State or foreign country) <u>U. S. A.</u> | | 14. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | |
| 15. FATHER'S NAME <u>Alexander Pryor</u> | | 16. MOTHER'S MAIDEN NAME <u>Mary E. Potell</u> | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 18. SOCIAL SECURITY NO. <u>None</u> | |
| 19. ADDRESS <u>State Police, Cumb. Md.</u> | | 20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY Sclerosis</u>
DUE TO (c) <u>---</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Benedict Skitarelic M.D.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/9/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>County Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Boris Stern Inc. Cumb. Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

1

11232

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, cause of death, and examiner details. The form is oriented vertically on the page.

6245

CERTIFICATE OF DEATH

06257
Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND
c. LENGTH OF STAY IN lb
12 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 CUMBERLAND
d. STREET ADDRESS
403 WASHINGTON ST.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
CHARLES D. RANDOLPH | | 4. DATE OF DEATH
Month Day Year
JUNE 6 19 59 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
FEB. 7, 1893 |
| 9. AGE (In years lost birthday)
66 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Design Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY
Federal Government | |
| 11. BIRTHPLACE (State or foreign country)
ENGLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
WILLIAM RANDOLPH | | 14. MOTHER'S MAIDEN NAME
Sara ? | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
414 01 6982 A | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 443X Congestive heart failure and terminal arrest
DUE TO (b) Hypertensive and arteriosclerotic heart disease 3 years
DUE TO (c) Generalized arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
30 days
? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 30 min , 19 59 , to 6 June , 19 59 , that I last saw the deceased alive on 6 June , 19 59 , and that death occurred at 7:20 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 172 S. Centre St. Cumberland, Md.
DATE SIGNED 6 June 59
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.
PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
June 9, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Meadowridge Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, 230 Baltimore Ave., Cumberland, Md. | | 24a. REC'D BY REGISTRAR
June 12 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 27

CERTIFICATE OF DEATH

1922

ALBANY

CUNNINGHAM

12 MONTHS

CLINTON

U.S. WASHINGTON

GENERAL HOSPITAL

CHARLES

BRADDOCK

UNIT 1

UNIT 1

LOCAL HOSPITAL

General Hospital

WILLIAM BAINBRIDGE

ALL OF DEPT. A GENERAL HOSPITAL, CUNNINGHAM, WASHINGTON

W. A. W. W. W. W. W.

Unit 1, 1900 Washington Avenue, Baltimore, Md.

Unit 1, 1900 Washington Avenue, Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06258

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Memorial Hospital | | d. STREET ADDRESS
526 Necessity Street | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
Nellie Cecelia Rennie | | 4. DATE OF DEATH
Month June Day 8 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 23, 1888 |
| 9. AGE (In years last birthday)
70 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Borden Shaft, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John F. Thomas | | 14. MOTHER'S MAIDEN NAME
Mary Davis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
David E. Rennie | | 526 Necessity Street
Cumberland, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary sclerosis
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden

---- |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Benedict Skitarelic</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED June 8, 1959 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
6/11/59 | 22c. NAME OF CEMETERY OR CREMATORY
Frostburg Memorial Park | 22d. LOCATION (City, town, or county) (State)
Frostburg, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | 24a. REC'D BY REGISTRAR
JUN 12 '59 | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. House</i> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6247

CERTIFICATE OF DEATH

06259

Reg. Dist. No.

| | | | | | | | |
|---|---|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND, MD. | | | | c. LENGTH OF STAY IN Ib
11 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES. | | | | d. STREET ADDRESS
RT.#1, BOX 189 | | | |
| 3. NAME OF DECEASED (Type or print)
First MARTHA Middle T. Last ROBERTSON | | | | 4. DATE OF DEATH
Month JUNE Day 24 Year 1959 | | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
FEB. 23, 1918 | | 9. AGE (In years last birthday) yrs. 41 | IF UNDER 1 YEAR
Months 4 Days 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
— — — | | 11. BIRTHPLACE (State or foreign country)
FROSTBURG, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CLEM RECKLEY | | | | 14. MOTHER'S MAIDEN NAME
FLOSSIE HOUSE | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
INFORMANT | | Address
MEMORIAL HOSPITAL CUMBERLAND, MARYLAND | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Stomach
151X DUE TO Abdominal carcinomatosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cachexia
(c) Duodenal ulcer | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 mo.
2 mo.
1 mo. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Duodenal ulcer | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
none | | | | | |
| 20c. TIME OF INJURY
Month. Day. Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from April 20, 1959 to June 24, 1959 ; that I last saw the deceased alive on June 24, 1959 , and that death occurred at 7:20 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<i>Edward L. Hallinan</i> | | ADDRESS (Street, city or town, state)
140 Bedford Street | | | | DATE SIGNED
6/25/59 | |
| PHYSICIAN'S NAME (Type)
DR. HALLINAN | | Cumberland, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 22b. DATE THEREOF
6/27/59 | 22c. NAME OF CEMETERY OR CREMATORY
DAVIS MEMORIAL RURAL CUMBERLAND, MD. | | 22d. LOCATION (City, town, or county) (State)
CUMBERLAND, MD. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Parks Funeral Home, Berkeley Springs, W. Va.</i> | | ADDRESS
Berkeley Springs, W. Va. | | 24a. REC'D BY REGISTRAR
JUN 29 '59 | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kraus</i> | | |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and file them with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

108250

CERTIFICATE OF DEATH

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARRIAGE
SINGLE
MARRIED
WIDOWED
DIVORCED
REMARKS

1

DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARRIAGE
SINGLE
MARRIED
WIDOWED
DIVORCED
REMARKS

105800

ALABAMA

MISSISSIPPI

LOUISIANA

25 DAYS

115 CALIF. STREET

RENTAL & AMERICAN AVE.

RENTAL

RENT

RENT

RENT 3 1/2

RENT

RENT

RENTAL, INLAND

RENTAL

RENTAL

RENTAL, INLAND

RENTAL, INLAND

RENTAL, INLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6249 CERTIFICATE OF DEATH

06261

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
9/27/58 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X R.F.D. Midland | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Allegany County Infirmary | | | | d. STREET ADDRESS
1 | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Lacy Middle Williams Last Ross | | | | 4. DATE OF DEATH
Month June Day 20 Year 1959 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH (1857)
12/13/57 | |
| 9. AGE (In years last birthday)
101 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Salem Ross | | | | 14. MOTHER'S MAIDEN NAME
Ellen Dye | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration
592X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gen. Arteriosclerosis
DUE TO (c) Chronic Nephritis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration
INTERVAL BETWEEN ONSET AND DEATH
? ? ? | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9/27/58 , 19___, to 6/20/59 , 19___, that I last saw the deceased alive on 6/20/59 , 19___, and that death occurred at 9:00 A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James E. McLean M.D. | | | | ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 6/20/59 | | | |
| PHYSICIAN'S NAME (Type) Dr. James E. McLean | | | | Cumberland, Maryland. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 6/23/59 | | Miller Cem. | | near Westernport, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
E. B. Bode | | | | ADDRESS
Westernport, Md. | | 24a. REC'D BY REGISTRAR
JUN 24 59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kline | | | |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

6250

| | | | |
|---|------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND
c. LENGTH OF STAY IN 1b
12 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SACRED HEART HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
WEST VIRGINIA
b. COUNTY
RIDGELEY,
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 85X-3
d. STREET ADDRESS
26 CARPENTER AVE.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
ARTHUR Sylvester ROWE | | 4. DATE OF DEATH
Month Day Year
JUNE 6, 1959 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/11-86 |
| 9. AGE (In years lost birthday) yrs.
73 | | 10. IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Store room clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
W. Md. Rwy. | |
| 11. BIRTHPLACE (State or foreign country)
Hagerstown, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
SAMUEL ROWE | | 14. MOTHER'S MAIDEN NAME
ETNA Krepps | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
705-10-5424 | |
| 17. INFORMANT
George C. Rowe | | Address
406 Chestnut St., Cumb. Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis
422.2 DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Syncope | | INTERVAL BETWEEN ONSET AND DEATH
Syncope | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5-25-59 to 6-6-59 , that I last saw the deceased alive on 6-6-59 , and that death occurred at 8:30 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 16 Greene St. Cumberland Md.
DATE SIGNED
ACTUAL SIGNATURE J. F. Johnson
PHYSICIAN'S NAME (Type) DR. J. F. JOHNSON | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
6/9/59 | 22c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles L. George | | 24. REC'D BY REGISTRAR
JUN 10 59 | |
| ADDRESS
Cumberland, Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Krause | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

IN SENATE,
 FEBRUARY 11, 1903.
 REPORT
 OF THE
 COMMISSIONER OF THE
 GENERAL LAND OFFICE,
 FOR THE YEAR
 1902.

6251

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
o. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
24 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SACRED HEART HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First GEORGE Middle ROWE Last HOMES, FREDERICK ST. | | 4. DATE OF DEATH
Month JUNE Day 14 Year 19 59 | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
FEB. 28, 1889 |
| 9. AGE (In years last birthday)
70 | | 10. IF UNDER 1 YEAR
Months 70 Days 70 Hours 70 Min. 70 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RAILROADER Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
B&O. | |
| 11. BIRTHPLACE (State or foreign country)
WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Ike Macgruder | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
— | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Cerebral Thrombosis, left temporal lobe, with small hemorrhage and necrosis and cerebral malacia.
DUE TO
(c) 3 weeks | | INTERVAL BETWEEN ONSET AND DEATH
Few hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 20th, 19 59 , to June 11th, 19 59 that I last saw the deceased alive on June 13th, 19 59 , and that death occurred at 12:05 M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Wyand F. Doerner, Jr. M.D. | | DATE SIGNED Algonquin Hotel | |
| PHYSICIAN'S NAME (Type) Wyand F. Doerner, Jr., M.D. | | Cumberland, Maryland. | |
| 22a. BURIAL, CREMATION, OR REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6/17/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Rose Thorn Cem. | | 22d. LOCATION (City, town, or county) (State)
Keyser W. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Louis Stein Inc. Cumb. Md. | | 24a. REC'D BY REGISTRAR
DATE JUN 17 59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

80803

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC HEALTH AND SAFETY
BUREAU OF COMMUNITY HEALTH SERVICES

1971

TO: [Illegible]
FROM: [Illegible]
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or report. The text is too faded to transcribe accurately.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6252 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06264

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN 1b 7 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital | | d. STREET ADDRESS 620 Shriver Ave | |
| 3. NAME OF DECEASED (Type or print) Anna M Ruble | | 4. DATE OF DEATH June 29 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 1, 1883 |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Cumberland, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Betzold | | 14. MOTHER'S MAIDEN NAME Mary S. Fries | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Memorial Hospital--Cumberland, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute cardiac failure
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic cardiovascular disease, advanced.--
(c) Fracture of left hip; Malnutrition, marked
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Fracture of left hip; Malnutrition, marked | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs. | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home in bathroom | |
| 20c. TIME OF INJURY Month, Day, Year 8:00 a.m. June 22 19 59 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. (City or town) (County) (State) Cumberland, Alleg. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 7/1/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cem. | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md. | | ADDRESS | |
| 24a. REC'D BY REGISTRAR JUL 2 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|-----------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased | | Sex | | Age | |
| John Doe | | Male | | 45 | |
| Residence | | Occupation | | Date of Death | |
| 123 Main St, Baltimore, MD | | Teacher | | June 1, 1950 | |
| Cause of Death | | Manner of Death | | Place of Death | |
| Acute myocardial infarction | | Natural | | Home | |
| History of Disease | | Previous Illnesses | | Date of Admission | |
| Hypertension, 10 years | | None | | June 1, 1950 | |
| Treatment | | Autopsy | | Remarks | |
| Digitalis, aspirin | | Yes | | Sudden death | |
| Signature of Examiner | | Signature of Physician | | Signature of Coroner | |
| J. H. Smith, M.D. | | Dr. J. K. Jones | | Mr. A. B. White | |

6272
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Allegany
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | c. LENGTH OF STAY IN 1b
22 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Gunter Hotel, E. Main St. | | d. STREET ADDRESS
29 Water Street | |
| 3. NAME OF DECEASED (Type or print)
First GEORGE Middle HENRY Last SANGED | | 4. DATE OF DEATH
Month 6 Day 5 Year 19 59 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-16-1889 |
| 9. AGE (In years last birthday)
69 yrs. | | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Operator | | 10b. KIND OF BUSINESS OR INDUSTRY
Restaurant | 11. BIRTHPLACE (State or foreign country)
Syria |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Unknown | |
| 14. MOTHER'S MAIDEN NAME
Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]
No None | |
| 16. SOCIAL SECURITY NO.
220-10-2142 | | 17. INFORMANT
Wm. H. Sanged, 29 Water St., Frostburg, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Failure - Rt. Side
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease
DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
12 days - years - | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from September, 1958 , to June 5, 1959 , that I last saw the deceased alive on June 2, 1959 , and that death occurred at 9:30 AM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 2 BROADWAY DATE SIGNED 6/5/59 | | | |
| ACTUAL SIGNATURE John B. Davis, M.D. | | PHYSICIAN'S NAME (Type) John B. DAVIS, MD. Frostburg Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6-7-1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Frostburg Memorial Park, Frostburg Md. | | 22d. LOCATION (City, town, or county) (State)
Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hafer Funeral Home | | 24a. REC'D BY REGISTRAR
DATE JUN 9 '59 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

1
ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6253

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
78yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1922 Bedford, St. | | e. STREET ADDRESS
1922 Bedford, St. | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Norma Elizabeth Schlund | | 4. DATE OF DEATH Month Day Year
June 1, 1959 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/13/81 |
| 9. AGE (In years last birthday) yrs.
78 | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeper at | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 11. BIRTHPLACE (State or foreign country)
Cumberland, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John C. Schlund | | 14. MOTHER'S MAIDEN NAME
Mary Gore | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
none | |
| 17. INFORMANT
Walter Schlund | | Address
Cumberland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 446X DUE TO Uremia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nephritis
(c) Cerebral Sclerosis Generalized
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ravages of age | | | INTERVAL BETWEEN ONSET AND DEATH
5 days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/1/59 , 19, to 6/1/59 , 19, that I last saw the deceased alive on 5/31/59 , 19, and that death occurred at 2:35 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
[Signature] | | ADDRESS (Street, city or town, state) DATE SIGNED
Cumberland, Md. 6/1/59 | |
| PHYSICIAN'S NAME (Type)
[Signature] | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
6/2/59 | 22c. NAME OF CEMETERY OR CREMATORY
Trinity Lutheran Cem. | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H. Lee Silcox | | ADDRESS
Cumberland, Md. | |
| 24a. REC'D BY REGISTRAR
JUN 3 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume | |

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6254

CERTIFICATE OF DEATH

06267

Reg. Dist. No.

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN lb
7/23/56 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Allegany County Infirmary | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lonaconing | |
| 3. NAME OF DECEASED (Type or print)
Augustine | | 4. DATE OF DEATH
Month June Day 18 Year 1959 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
I/I/1870 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11. BIRTHPLACE (State or foreign country)
Scicily | |
| 13. FATHER'S NAME
Igniazio Pace | | 14. MOTHER'S MAIDEN NAME
Marina | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 17. INFORMANT P.O.Box 599 Address Cumberland, Md.
Allegany County Infirmary Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic myocardial Degeneration
592X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis
DUE TO (c) Chronic Nephritis | | INTERVAL BETWEEN ONSET AND DEATH
?
?
? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Senile Deterioration | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 7/23/56 , 19 to 6/18/59 , 19, that I last saw the deceased alive on 6/18/59 , 19, and that death occurred at 12:20 P , from the causes and on the date stated above. | | ADDRESS (Street, city or town, state)
49 Greene Street | |
| ACTUAL SIGNATURE James E. McLean M.D. | | DATE SIGNED 6/18/59 | |
| PHYSICIAN'S NAME (Type)
Dr. James E. McLean | | Cumberland, Maryland. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
6/20/59 | 22c. NAME OF CEMETERY OR CREMATORY
St. Marys Cemetery | 22d. LOCATION (City, town, or county) (State)
Lonaconing, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
George Eichhorn | | 24a. REC'D BY REGISTRAR
DATE JUN 22 '59 | |
| ADDRESS
Lonaconing, Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NO. 1

1914

DECEASED
NAME
AGE
SEX
RACE
BIRTH DATE
BIRTH PLACE
MARRIAGE DATE
MARRIAGE PLACE
OCCUPATION
EDUCATION
RELIGION
MILITARY SERVICE
CIVIL SERVICE
SOCIETY AFFILIATIONS
HABIT OF SMOKING
HABIT OF DRINKING
PREVIOUS ILLNESSES
CAUSE OF DEATH
MANNER OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
HOURS OF DAY
MONTH OF YEAR
YEAR OF DEATH

1914

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06268

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Pennsylvania b. COUNTY Bedford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyndman ✓ | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Memorial Hospital--D.O.A. | | d. STREET ADDRESS 75 X - 3 | |
| 3. NAME OF DECEASED (Type or print)
ROBERT JAMES SHAFFER | | 4. DATE OF DEATH
Month June Day 12 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 19, 1936 |
| 9. AGE (In years, months, days)
22 yrs. | | 10. IF UNDER 1 YEAR
Months 2 Days 2 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Cleaning | |
| 11. BIRTHPLACE (State or foreign country)
Hyndman, Pa. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Claude Burton Shaffer | | 14. MOTHER'S MAIDEN NAME
Nellie Bruck | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
172-30-4298 | |
| 17. INFORMANT
B.B. Shaffer, Hyndman, Pa. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intracranial Hemorrhage
DUE TO (b) Skull Fracture
DUE TO (c) 823X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
5-10 Min.
5-10 Min. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
<input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Passenger in Auto Wreck | |
| 20c. TIME OF INJURY
Month, Day, Year
1:20 June 12 1959 | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Street | | 20f. (City or town) (County) (State)
Cumberland, Alleg. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<i>Benedict Skitarelic</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
Benedict Skitarelic, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
June 15, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Hyndman, Pa. Cemetery | | 22d. LOCATION (City, town, or county) (State)
Hyndman, Pa. Bedford Co. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Harvey H. Feigler</i> | | 24a. REC'D BY REGISTRAR
DATE JUN 18 '59 | |
| ADDRESS
Hyndman, Pa. | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kross</i> | |

MEDICAL CERTIFICATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6273

CERTIFICATE OF DEATH

Reg. Dist. No.

07436

| | | | | | | | |
|---|------------------------------|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | c. LENGTH OF STAY IN 1b
Lifetime | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
22 Frostburg | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
Miners Hospital | | | | d. STREET ADDRESS
47 Broadway | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First EDGAR Middle WILLIAM Last SHUCK | | | | 4. DATE OF DEATH
Month June Day 30 Year 19 59. | | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5-29-1906 | | 9. AGE (In years last birthday)
53 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired)
Plumbing contractor | | 10b. KIND OF BUSINESS OR INDUSTRY
Own business | | 11. BIRTHPLACE (State or foreign country)
Clarysville, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Robert Shuck | | | | 14. MOTHER'S MAIDEN NAME
Nellie Klosterman | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
214-05-7885 | | 17. INFORMANT
William Shuck, 84 Pine Street, Frostburg, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Myocardial Infarction
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis
DUE TO (c) _____
INTERVAL BETWEEN ONSET AND DEATH
1 1/2 hrs.
72 hrs.? | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
None | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
XXXXXX | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
XXXXXX | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. XXXX 19
p. m. _____ | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6/30/59 , 19____, to 6/30/59 , 19____, that I last saw the deceased alive on 6/30/59 , 19____, and that death occurred at 10:30 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 48 Broadway DATE SIGNED 7/1/59
ACTUAL SIGNATURE <i>Martin M. Rothstein</i> M.D. _____
PHYSICIAN'S NAME (Type) Martin M. Rothstein M.D. Frostburg, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/4/59 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Michaels Cemetery | | 22d. LOCATION (City, town, or county) (State)
Frostburg Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hafer Funeral Home
Bush H. Winters 23 E. Main, Frostburg, Md. | | | | 24a. REC'D BY REGISTRAR
JUL 13 '59 | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kraus</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

| | | | |
|---|--|---------------------------------------|--|
| NAME OF DECEASED
ALICE MARY | | SEX
FEMALE | |
| DATE OF BIRTH
JAN 1 1900 | | PLACE OF BIRTH
BALTIMORE, MD | |
| OCCUPATION
HOUSEWIFE | | MARITAL STATUS
MARRIED | |
| DECEASED AT
HOME | | PLACE OF DEATH
BALTIMORE, MD | |
| CAUSE OF DEATH
HEART DISEASE | | MANNER OF DEATH
NATURAL | |
| DATE OF DEATH
JAN 15 1950 | | TIME OF DEATH
10:00 AM | |
| SIGNATURE OF PHYSICIAN
J. H. [Signature] | | SIGNATURE OF REGISTRAR
[Signature] | |
| COUNTY
BALTIMORE | | CITY
BALTIMORE | |
| STATE
MARYLAND | | ZIP CODE
21201 | |



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06269

6256

| | | | |
|---|-------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> | | c. LENGTH OF STAY IN 1b <u>Life</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>452 Walnut Street</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>B.</u> Last <u>Shumacher</u> | | 4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1959</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/11/89</u> |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Cumberland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John L. Walz</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Hoffman</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Charles Walz</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Accident</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Art Sclerotic</u>
DUE TO (c) <u>5 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED White at work <input type="checkbox"/> NOT white at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1/4/53</u> , 19 <u>53</u> , to <u>6/2/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5/24/59</u> , 19 <u>59</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> M.D. | | ADDRESS (Street, city or town, state) <u>Cumberland Md</u> DATE SIGNED <u>6/3/59</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/5/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u> ADDRESS <u>Cumb. Md</u> | | 24a. REC'D BY REGISTRAR DATE <u>JUN 5 '59</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> | |

CERTIFICATE OF DEATH

6258

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED
<i>JOHN J. SMITH</i> | | 2. SEX
<i>Male</i> | | 3. AGE
<i>45</i> | | 4. DATE OF BIRTH
<i>Jan 15 1900</i> | | 5. PLACE OF BIRTH
<i>Baltimore, Md.</i> | | 6. OCCUPATION
<i>Engineer</i> | |
| 7. MARITAL STATUS
<i>Married</i> | | 8. COLOR
<i>White</i> | | 9. HEIGHT
<i>5' 8"</i> | | 10. WEIGHT
<i>160</i> | | 11. BUILD
<i>Medium</i> | | 12. EDUCATION
<i>High School</i> | |
| 13. PRESENT ADDRESS
<i>1234 Main St., Baltimore, Md.</i> | | 14. DATE OF DEATH
<i>Dec 10 1945</i> | | 15. TIME OF DEATH
<i>10:30 AM</i> | | 16. PLACE OF DEATH
<i>Home</i> | | 17. CAUSE OF DEATH
<i>Heart Disease</i> | | 18. MANNER OF DEATH
<i>Natural</i> | |
| 19. SIGNATURE OF PHYSICIAN
<i>J. H. Smith</i> | | 20. SIGNATURE OF WITNESSES
<i>W. J. Brown, M. K. Green</i> | | 21. SIGNATURE OF DECEASED
<i>John J. Smith</i> | | 22. SIGNATURE OF FUNERAL HOME
<i>None</i> | | 23. SIGNATURE OF BURIAL PLACE
<i>None</i> | | 24. SIGNATURE OF REGISTRAR
<i>None</i> | |
| 25. REMARKS
<i>Deceased died of natural causes, heart disease.</i> | | 26. SIGNATURE OF REGISTRAR
<i>None</i> | | 27. SIGNATURE OF FUNERAL HOME
<i>None</i> | | 28. SIGNATURE OF BURIAL PLACE
<i>None</i> | | 29. SIGNATURE OF DECEASED
<i>None</i> | | 30. SIGNATURE OF WITNESSES
<i>None</i> | |



1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness or who has attended him at the time of death.

2. The cause of death should be stated in plain language, and should be based on the findings of the physician or other qualified person who has attended the deceased during his last illness or who has attended him at the time of death.

3. The manner of death should be stated in plain language, and should be based on the findings of the physician or other qualified person who has attended the deceased during his last illness or who has attended him at the time of death.

4. The signature of the physician or other qualified person who has attended the deceased during his last illness or who has attended him at the time of death, and the signature of the registrar, must be written in ink.

5. This certificate is to be filed in the office of the registrar of deaths, and a copy of it is to be sent to the office of the health officer of the city or county in which the deceased resided at the time of death.

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6257

CERTIFICATE OF DEATH

06270

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
60 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
109 Jackson St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Ellen Last Snyder | | 4. DATE OF DEATH
Month June Day 29 Year 19 59 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 29, 1881 |
| 9. AGE (In years last birthday)
78 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (State or foreign country)
Terra Hute, Ind. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Thomas Leake | | 14. MOTHER'S MAIDEN NAME
Mary Stevens | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
no | |
| 17. INFORMANT
Mrs. Howard Iser, Cumberland, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 725x DUE TO Thaemia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis
(c) Arthritis of Spine | | INTERVAL BETWEEN ONSET AND DEATH
3 wks
12 wks
2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 20 , 19 59 , to June 29 , 19 59 , that I last saw the deceased alive on June 20 , 19 59 , and that death occurred at 7:55 P. M., from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 236 Virginia Ave. DATE SIGNED June 30-59 | |
| ACTUAL SIGNATURE Clay E. Durrett M.D. | | 23b. REGISTRAR'S SIGNATURE Arthur E. Hays | |
| PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett | | Cumberland, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
July 2, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James F. Scarpelli, Cumberland, Md. | | 24a. REC'D BY REGISTRAR
JUL 2 '59 | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE | |

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6287 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06271

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Garrett | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Luke | c. LENGTH OF STAY in 1b
1 day | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Lake Park 11x-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
W.Va. Plup & Paper Mill | | d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Lloyd Junior Stark | | 4. DATE OF DEATH
Month June Day 7 Year 1959 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Mar. 4, 1915 |
| 9. AGE (In years last birthday)
44 yrs. | | IF UNDER 1 YEAR
Months 44 Days 44 | IF UNDER 24 HRS.
Hours 44 Min. 44 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machine coater | | 10b. KIND OF BUSINESS OR INDUSTRY
Paper Mill | 11. BIRTHPLACE (State or foreign country)
Penn. |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Lloyd Stark | |
| 14. MOTHER'S MAIDEN NAME
Nancy Long | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | |
| 16. SOCIAL SECURITY NO.
216-09-8488 | | 17. INFORMANT
Mrs. Lloyd J. Stark -Mt. Lake Park, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock, Exanguination
912.3 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Traumatic Amputation of right leg
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
5-10 Min.
5-10 Min. | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Slipped in agitator at W.Va. Pulp and Paper Co. | |
| 20c. TIME OF INJURY
Month, Day, Year
4:15 Hour p. m. June 7, 1959 | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Factory | 20f. (City or town) (County) (State)
Luke, Allegany, Maryland |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6/10/59 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Philos | | 22d. LOCATION (City, town, or county) (State)
Westernport, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
E. J. Boal | | 24a. REC'D BY REGISTRAR
JUN 9 '59 | |
| ADDRESS
Westernport, Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur E. Hanna | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06273

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Doa Memorial Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland
b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Rural
d. STREET ADDRESS RD#5 Winchester Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) William Ezra Suder | | | | 4. DATE OF DEATH June 28, 1959 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 24, 1890 | |
| 9. AGE (In years last birthday) 69 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James Henry Suder | | | | 14. MOTHER'S MAIDEN NAME Matilda Geiger | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-05-7802 | | 17. INFORMANT Mrs. Nina Suder, Cumberland, Md. RD#5 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.1 MYOCARDIAL INFARCTION
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY DISEASE
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 HRS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6.27 , 19 59 , to 6.28.59 , 19____, that I last saw the deceased alive on 6.28.59 , 19____, and that death occurred at 4:25 P.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William P. James M.D. | | | | ADDRESS (Street, city or town, state) 441 N. CENTRE ST DATE SIGNED 6.30.59 | | | |
| PHYSICIAN'S NAME (Type) WILLIAM P. JAMES, M.D. | | | | CUMBERLAND, MD. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF July 1, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Park | | 22d. LOCATION (City, town, or county) (State) Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Layler ADDRESS Hyndman, Pa. | | | | 24a. REC'D BY REGISTRAR JUL 8 '59 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Knecht | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg | | c. LENGTH OF STAY IN 1b 3 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Maude J. Taylor | | 4. DATE OF DEATH June 9th, 1959 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Apr. 16th, 1886 |
| 9. AGE (In years last birthday) 73 yrs. | | 10. IF UNDER 1 YEAR: Months 7 Days 3 Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own housework | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Benjamin Jenkins | | 14. MOTHER'S MAIDEN NAME Jane Toby | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 213-09-6608 | |
| 17. INFORMANT Mrs. Geo. Kroll | | Address 203 E. Main St., F'bg., Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary artery thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension
DUE TO
(c) Diabetes | | INTERVAL BETWEEN ONSET AND DEATH
7 days
2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 3, 1959 to June 9, 1959 , that I last saw the deceased alive on June 9, 1959 and that death occurred at 10:10 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE W. O. McLane M.D. | | ADDRESS (Street, city or town, state) 167 E. Main Street, June 9, 1959 | |
| PHYSICIAN'S NAME (Type) W. O. McLane M.D. | | Frostburg, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 6-12-59 | |
| 22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park | | 22d. LOCATION (City, town, or county) (State) Frostburg, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst | | ADDRESS Frostburg, Md. | |
| 24a. REC'D BY REGISTRAR June 15 '59 | | 24b. REGISTRAR'S SIGNATURE Orville S. Kneass | |

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6259

CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
23 Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
122 Park Avenue, Park Heights | | | | e. STREET ADDRESS
122 Park Avenue, Park Heights | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Ralph Herbert Taylor | | | | 4. DATE OF DEATH
Month Day Year
June 21 1959 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 24, 1911 | 9. AGE (In years last birthday)
47 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Senior Clerk Allegany | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Balistics | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | |
| 13. FATHER'S NAME
Willmot O. Taylor | | | | 14. MOTHER'S MAIDEN NAME
Ella Reis | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
Yes W.W. II | | | | 16. SOCIAL SECURITY NO.
171- 61- 1346 | | 17. INFORMANT
Mrs. Frances Taylor | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cordial arrest
443X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerosis and hypertension Cardio-vascular 2 years
DUE TO Disease.
(c) | | | | INTERVAL BETWEEN ONSET AND DEATH
Instantly | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0 | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 21 June , 19 59 , to 21 June , 19 59 , that I last saw the deceased alive on _____, 19 _____, and that death occurred at 4:30 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W. Alfred Van Ormer M.D. | | | | ADDRESS (Street, city or town, state) 122 South Centre Street | | | |
| DATE SIGNED 22 June 1959 | | | | | | | |
| PHYSICIAN'S NAME (Type) W. Alfred Van Ormer, M.D. Cumberland, Allegany County, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6/24/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Frostburg Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Frostburg, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ruth E. Silcox | | | | ADDRESS
Cumberland Maryland | | 24a. REC'D BY REGISTRAR
JUN 23 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | | | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOTE: Mr. Taylor currently has been under the care of Dr. R. W. Ballin for treatment of the listed diagnoses and was seen a few weeks before death by him.

100-1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|--|--|
| <p>1. NAME OF DECEASED
 [Faint text]</p> | | <p>2. SEX
 [Faint text]</p> | | <p>3. AGE
 [Faint text]</p> | |
| <p>4. DATE OF DEATH
 [Faint text]</p> | | <p>5. TIME OF DEATH
 [Faint text]</p> | | <p>6. PLACE OF DEATH
 [Faint text]</p> | |
| <p>7. CAUSE OF DEATH
 [Faint text]</p> | | <p>8. MANNER OF DEATH
 [Faint text]</p> | | <p>9. SIGNATURE OF PHYSICIAN
 [Faint text]</p> | |
| <p>10. SIGNATURE OF REGISTRAR
 [Faint text]</p> | | <p>11. SIGNATURE OF WITNESS
 [Faint text]</p> | | <p>12. SIGNATURE OF DECEASED
 [Faint text]</p> | |

DO NOT WRITE IN THESE SPACES

IF DECEASED WAS A FOREIGNER, GIVE NAME AND PLACE OF BIRTH

IF DECEASED WAS A NATURALIZED CITIZEN, GIVE DATE AND PLACE OF NATURALIZATION

IF DECEASED WAS A NATURAL BORN CITIZEN, GIVE DATE AND PLACE OF BIRTH

IF DECEASED WAS A NATURAL BORN CITIZEN, GIVE DATE AND PLACE OF BIRTH

IF DECEASED WAS A NATURAL BORN CITIZEN, GIVE DATE AND PLACE OF BIRTH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6250 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06276

Reg. Dist. No.

| | | | | | |
|--|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
02 Cumberland | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
210 Cecelia Street | | | d. STREET ADDRESS
210 Cecelia Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) JAMES LEE THRASHER | | | 4. DATE OF DEATH
Month December Day 6/7/59 Year 19 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 11, 1892 | | 9. AGE (In years last birthday)
66 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
Celanese Corp. | | 11. BIRTHPLACE (State or foreign country)
Rawlings, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
Nelson Thrasher | | |
| 14. MOTHER'S MAIDEN NAME
Catherine Shepherd | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
yes WW 1 | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT
Mrs. Myrtle Thrasher Cumberland, Maryland | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis
DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH
sudden
----- |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED June 7, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
June 10, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | |
| 22d. LOCATION (City, town, or county)
Cumberland, Maryland | | (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | 24a. REC'D BY REGISTRAR
JUN 12 '59 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Haas |

MEDICAL CERTIFICATION

2

FOR STATE
HEALTH DEPT.

100

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|-----------------------------------|--|-----------------------------------|--|---|--|
| Name of Deceased | | Sex | | Age | |
| John A. Baker, Maryland, Maryland | | Male | | 45 | |
| Date of Death | | Place of Death | | Cause of Death | |
| June 1, 1935 | | John A. Baker, Maryland, Maryland | | Heart failure, due to coronary artery disease | |
| Time of Death | | Occupation | | Manner of Death | |
| 10:00 AM | | John A. Baker, Maryland, Maryland | | Natural | |
| Signature of Medical Examiner | | Signature of Coroner | | Signature of Registrar | |
| John A. Baker, Maryland, Maryland | | John A. Baker, Maryland, Maryland | | John A. Baker, Maryland, Maryland | |
| Date of Certificate | | Date of Death | | Date of Burial | |
| June 7, 1935 | | June 1, 1935 | | June 1, 1935 | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06277

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | |
|---|-------------------------------------|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany 6261 MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Pa b. COUNTY Fayette | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
Mt. Savage, Md | | c. LENGTH OF STAY IN 1b
1 Month | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Connellsville 75x3 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Memorial Hospital--DOA | | | d. STREET ADDRESS
202 E. Fayette St | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First James Middle Dalton Last Troutman | | | 4. DATE OF DEATH
Month June Day 24 Year 19 59 | | |
| 5. SEX
M. | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 31, 1884 | | 9. AGE (In years last birthday)
75 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Public | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. |
| 13. FATHER'S NAME
Amos Troutman | | | 14. MOTHER'S MAIDEN NAME
Isabel Blubaugh | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
213-09-6576 | 17. INFORMANT
Woodrow Troutman Address Cleveland 11, Ohio 15810 Madison Ave | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 434.4 Acute Cardiac Failure, Pulmonary edema
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Cardiac Hypertrophy, Marked
(c) stating the underlying cause lost.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Coronary osteal narrowing, right and left | | | | | INTERVAL BETWEEN ONSET AND DEATH
sudden |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 19 o. m. p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Benedict Skitarellic | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Benedict Skitarellic, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | June 26, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
6-27-59 | 22c. NAME OF CEMETERY OR CREMATORY
Somerset Memorial Park | | 22d. LOCATION (City, town, or county) (State)
Somerset Pa | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
H.P. Konlaw, Meyersdale, Pa | | ADDRESS | | 24a. REC'D BY REGISTRAR
JUL 2 '59 | 24b. REGISTRAR'S SIGNATURE
C. H. H. H. |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

ANDERSON, J. R.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6262 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06278

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | |
|--|-------------------------------|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SACRED HEART HOSPITAL | | | d. STREET ADDRESS
Valley Rd. Rt. 1 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
GEORGE HENRY TWIGG | | | 4. DATE OF DEATH
Month JUNE Day 9 Year 19 59 | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MAY 25, 1901 | | 9. AGE (In years last birthday)
58 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mill Worker | | 10b. KIND OF BUSINESS OR INDUSTRY
KELLY SPRINGFIELD | | 11. BIRTHPLACE (State or foreign country)
PENNA. Hyndman | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
CECIL TWIGG | | | 14. MOTHER'S MAIDEN NAME
EDNA JANE LEIGHTY | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
YES | | 16. SOCIAL SECURITY NO.
2ND. WORLD WAR 214-05-7635 | | 17. INFORMANT
Mrs. Howard Hillegass Cumberland, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Coronary Sclerosis
DUE TO
(c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <i>Benedict Skitarelic</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | June 9, 1959 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
June 11, 1959 | | 22c. NAME OF CEMETERY OR CREMATORY
Zion Memorial Park | |
| 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | | 24a. REC'D BY REGISTRAR
DATE JUN 12 '59 | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kraus</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | | ADDRESS | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6263

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>ALLEGANY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CUMBERLAND</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>MICHAEL S. TWIGG</u> | | | | 4. DATE OF DEATH Month Day Year
<u>JUNE 12 1959</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>SEPT. 22-1915</u> | |
| 9. AGE (In years last birthday) <u>43</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tractor driver</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Freight</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>ORBE TWIGG</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Nettie Slider</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>220-10-4947</u> | | INFORMANT Address
<u>PT'S CHART</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Acute Myocardial Infarction</u> DUE TO
(c) <u>Hypertensive & Arteriosclerotic Heart Disease</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>8 hours</u>
<u>2 days</u>
<u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Related diagnosis: Pt. had his first myocardial infarction Apr 10, 1959</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 20, 1959</u> to <u>June 12th, 1959</u> , that I last saw the deceased alive on <u>June 12th, 1959</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Algonquin Hotel,</u> DATE SIGNED _____
ACTUAL SIGNATURE <u>Wyand P. Doerner</u> M.D. <u>Algonquin Hotel,</u>
PHYSICIAN'S NAME (Type) <u>WYAND DOERNER, M.D.</u> <u>ALGONQUIN HOTEL, Cumberland, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>6/14/59</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt Pleasant Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Ruth E. Silcox</u> <u>Cumberland</u> <u>Maryland</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>JUN 16 '59</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hume</u> | |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filled with

6275

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---|---|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Garrett | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | | | | c. LENGTH OF STAY IN 1b
6 weeks | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Miner's Hospital | | | | d. STREET ADDRESS
R. D. #2 | | | |
| 3. NAME OF DECEASED (Type or print)
LULA GERTRUDE WAMPLER | | | | 4. DATE OF DEATH
Month June Day 19th Year 1959 | | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-21-1909 | | 9. AGE (In years last birthday)
49 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | | 11. BIRTHPLACE (State or foreign country)
Garrett County | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John L. Crowe | | | | 14. MOTHER'S MAIDEN NAME
Ida Ravenscroft | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
217-28-0528 | | 17. INFORMANT
Address Md.
Mr. Edward L. Wampler, R.D.#2, Frostburg, | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Epithelioma Anus
191.5 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Frostburg | | (County) (State) | |
| 21. I certify that I attended the deceased from 1956 , 19 to June 19, 1959 , that I last saw the deceased alive on June 18, 1959 , and that death occurred at 8:20 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
WOM Lane M.D. Frostburg June 20 1959
ACTUAL SIGNATURE
PHYSICIAN'S NAME (Type) WOM Lane | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6-22-59 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cemetery | | 22d. LOCATION (City, town, or county) (State)
Rt. 40, Frostburg Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Beverly H. Wooten | | | | ADDRESS
Hafer Funeral Home | | 24a. REC'D BY REGISTRAR
DATE JUN 24 '59 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur E. Kraus | | | |

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06281
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany 6264 MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN 1b
Life | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Memorial Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 4. DATE OF DEATH
Month June Day 9 Year 1959 | | | | 5. STREET ADDRESS
Route 2, Baltimore Pike | | | |
| 3. NAME OF DECEASED (Type or print)
First John Middle E Last Welch | | | | 6. DATE OF BIRTH
Month Feb. Day 4 Year 1927 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. AGE (In years last birthday)
32 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
Garage | | 11. BIRTHPLACE (State or foreign country)
Cumberland, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
James E. Welch | | | | 14. MOTHER'S MAIDEN NAME
Graci Clara Rice | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
Yes WW2 | | 16. SOCIAL SECURITY NO.
212 24 1636 | | 17. INFORMANT
Kathaleen Welch Cumberland, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion, Left
 420.1 DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis
 DUE TO (c) _____</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH
Sudden</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> June 9, 1959 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
6/12/1959 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Peter & Pauls Cem | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Byron Knight | | | | 24a. REC'D BY REGISTRAR
Cumberland, Md. | | 24b. REGISTRAR'S SIGNATURE
June 11 '59 | |

MEDICAL CERTIFICATION

Reg. Dist. No.

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Allegany | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN lb
3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
425 Chestnut Street | | Cumberland, Md. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Sacred Heart Hospital | | | | d. STREET ADDRESS
Cumberland, Maryland | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Elizabeth | | First
Elizabeth | | Middle
Windemuth | | Last
Windemuth | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9-13-82 | |
| 9. AGE (In years last birthday)
76 yrs. | | IF UNDER 1 YEAR
Months 6 Days 30 | | IF UNDER 24 HRS.
Hours 1959 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Maryland Cumberland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Windemuth | | 14. MOTHER'S MAIDEN NAME
Wilhelmina Borchert | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Pt.'s chart | | Address
Sacred Heart Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary 4th class
171X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) /
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
8 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6-24 , 19 59 , to 6-30 , 19 59 , that I last saw the deceased alive on 6-30 , 19 59 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above.
LEWIS BRINGS M.D. 576 Green Mt.
ADDRESS (Street, city or town, state) Cumberland Md
DATE SIGNED 7-1-59 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
7/3/59 | | 22c. NAME OF CEMETERY OR CREMATORY
Greenmount Cemetery | | 22d. LOCATION (City, town, or county) (State)
Cumberland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John J. Hafer, Cumberland, Maryland | | ADDRESS | | 24a. REC'D BY REGISTRAR
JUL 6 | | 24b. REGISTRAR'S SIGNATURE
Walter S. Haug | |

VS A15 (4)
15M 10/57

VS A1S (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6289

CERTIFICATE OF DEATH

Reg. Dist. No.

06283

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland | | c. LENGTH OF STAY IN lb years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 2, Creek Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) OLIVE VA METER WITT | | 4. DATE OF DEATH June 10 19 59 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 26, 1912 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 9b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 10. FATHER'S NAME John W. Stafford, Sr. | | 11. MOTHER'S MAIDEN NAME Elsie Mae Messick | |
| 12. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 13. SOCIAL SECURITY NO. Rt. 2, Creek Road | |
| 14. INFORMANT Chas. F. Witt, Cumberland, Maryland | | 15. BIRTHPLACE (State or foreign country) Rt. 2, Creek Rd. Cumberland, Maryland, USA | |
| 16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA, BREAST (LEFT)
170x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 19a. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | 19b. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20b. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4-14 1958 to 6-10 1959 that I last saw the deceased alive on 6-9 1959 , and that death occurred at 9:10 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Frank Cawley | | DATE SIGNED 4-12-59 | |
| PHYSICIAN'S NAME (Type) Frank Cawley M.D. La Vale, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 13, 1959 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Meth. Cem | | 22d. LOCATION (City, town, or county) (State) Allegany County, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland | | 24a. REC'D BY REGISTRAR DATE JUN 16 '59 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

